PRINTED: 03/21/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495258	B. WING		C 02/23/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434	02/23/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
F 000	INITIAL COMMENTS	3	F 00		
	2/21/17 through 2/22/was conducted 2/22/complaint was investic corrections are required following 42 CFR Par Care requirements. I identified in the area (Neglect, Exploitation Level 4, widespread, Substandard Quality) After accepting the Aremoval of the Immediatermining that the I removed, the deficier and Severity level 2,	survey was conducted /17. An extended survey 17 through 2/23/17. One igated. Significant red for compliance with the rt 483 Federal Long Term mmediate Jeopardy was of Freedom from Abuse, at a Scope and Severity and which constituted of Care. definition of the constituted of the			3/17/17
SS=D	/N. I.	ROOM, ETC)	F 15		3/1//1/
	(g)(14) Notification of	Changes.			
	consult with the resid	nediately inform the resident; ent's physician; and notify, her authority, the resident en there is-			
	results in injury and h	ving the resident which las the potential for requiring			
ARORATORY	DIRECTOR'S OR PROVIDER!	SUPPLIER REPRESENTATIVE'S SIGNATURE	=	TITLE	(X6) DATE

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 03/14/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495258	B. WING				23/2017
	ROVIDER OR SUPPLIER			25	TREET ADDRESS, CITY, STATE, ZIP CODE 580 PRUDEN BOULEVARD UFFOLK, VA 23434	1 021	20/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 157	mental, or psychosocy deterioration in health status in either life-the clinical complications (C) A need to alter treat a need to discontinue treatment due to advocommence a new for (D) A decision to transcident from the facisy 483.15(c)(1)(ii). (ii) When making noticy (14)(i) of this section, all pertinent informatics available and proviphysician. (iii) The facility must a resident and the resident and the resident and the resident and the resident and specified in \$483.10 (B) A change in room as specified in \$483.10 (B) A change in regulation (e)(10) of this section (iv) The facility must a update the address (uphone number of the	ge in the resident's physical, sial status (that is, a in, mental, or psychosocial reatening conditions or it; eatment significantly (that is, a an existing form of erse consequences, or to im of treatment); or sfer or discharge the lity as specified in fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the dent representative, if any, or roommate assignment 10(e)(6); or ent rights under Federal or ins as specified in paragraph	F	157			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE S COMPL	
		495258	B. WING _			02/2) 23/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		-	
ΔΙΙΤΙΙΜΝ	CARE OF SUFFOLK			2580 PRUDEN BOULEVARD			
AUTOMIN	CARL OF SOFFOLK			SUFFOLK, VA 23434			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
F 157	facility document revir a complaint investigat immediately consult we the Resident Represe treatment significantly physical restraint to peresidents in the surve #3, 1. The facility staff fail with Resident #1's Phe Resident Representate treatment prior to the belt as a physical resion 2/9/17. A gait belt resident from rising frapproximately 8:00 per 10:00-10:30 am the formula of the 2. The facility staff fare with Resident #3's Pherical Representate treatment prior to the	iews, clinical record review, ew and during the course of tion the facility staff failed to with the Physician and notify entative for the need to alter y for the implementation of a prevent movement for 2 of 10 ey sample, Resident #1 and eled to immediately consult hysician and notify the tive for the need to alter implementation of a gait traint to prevent movement is was utilized to prevent the om the wheelchair from	F 1	F 157 1. A MD and RP noti 2/22/17 re: past use of the res res. # 1 & 3. B. No gait belt (used as or any other restraint is in use 2. All residents are at risk issue. 3. A. In-service for licenses staff by the ADON on the regulacility policy on the use of resinclude: - notification of MD & RP - identification of the medical restraint - obtaining an order and paranuse 3.B The ADON or designee will licensed nursing staff that no rorder will be initiated with the I first discussing it with the DON Administrator. 4. Any resident with a restraint audited by the DON to ensure regulation for use and facility prollowed.	traint for s a restrai at this tin for this ed nursing lation and traints to need for meters for ll in-servi restraint MD befor I and/or t will be the	ne.	
	The findings included			This audit will be ongoing and results will be shared in QAPI 5. 3/17/17		5.	
	complaint alleged a rechair restrained all da resident identified in t #1. Resident #1 was original complex complaint alleged a rechair restrained all da resident #1.	t on February 15, 2017. The esident had been left in a					

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F 157	Continued From page	e 3	F ·	157			
	for acute urinary rete included BPH (benig Alzheimer's dementia	n prostatic hyperplasia), and					
	with an assessment of 1/31/17 coded the repossible 15 on the Bl Mental Status), indicaseverely impaired da The resident was coordisorganized thinking any behaviors. The rebetween locations in corridor on the unit with water Mobility device wheelchair. The resident device wheelchair. This were cord and the compound of	as inaccurate as the clinical rehensive Resident re evidenced the resident which is prior to the ARD. ed Plan of Care initiated the resident was identified as ed safety related to Alzheimer's dementia, poor coma, history of chronic leg Fall on 1/8/17 and fall on the resident will not sustain					
		m, the Director of Nursing ed about the allegation of					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		495258	B. WING		C 02/23/2017
	ROVIDER OR SUPPLIER CARE OF SUFFOLK			STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434	32.20.20.11
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	D BE COMPLETION
F 157	While in the DON's of provided with a copy report of this allegatin noted Resident #1 "Verestraining him to the if the Physician and were notified by the sused to restrain Resident Housed to restrain Resident Housed to restrain Order Completed, Disconting through 2/28/17 was physician order(s) of restraint, reason for restraint, reason for restraint per the facility had called the resident, his responded me in forever does restraints anym was notified that Responded with a gain notification of a fall of did not notify mehime". When asked, "them (facility) to informade aware the resident Representation in the notification of the notific	e 4 Instrained with a gait belt. Instrained with a gait belt. Instrained with a gait belt. Instrained with a gait belt was found with a gait belt was found with a gait belt was dent Representative facility that a gait belt was dent #1, she stated, "No". Summary Report for Active, mued date range 1/1/17 reviewed. There were no obtained that specified type of use, and the duration of the lity restraint policy dated ontacted via phone on The Physician was asked if the obtain an order to restrain wonse was, "No, no one has about restraintswhoever hore?"When asked if he sident #1 was physically the belt in a wheelchair after in 2/9/17, he stated, "They in being restrained is news to Would you have expected myou after they had been dent was restrained, he so Notes evidenced the lative (RR) was not notified level to alter treatment lementation of a physical	F 15	7	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	, ,	DATE SURVEY COMPLETED
		495258	B. WING			C 02/23/2017
	ROVIDER OR SUPPLIER CARE OF SUFFOLK			STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434	I	02/23/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 157	The clinical record e Representative was benefits of (restraint Informed Consent for facility restraint policity restraint policity restraint policity restraint policity restraint with a gainevening of 2/9/17 at prevent movement. In urses station for surgait belt all night. At am on 2/10/17 the Resident's room and asleep, upon attempt to put him into the bowas wrapped around behind the wheelchaimmediately wheeler of Nursing (DON) of restraint. The restraint and the resident was was found. A facility During the investigate Practical Nurse (LPN days (2/10-2/12/17). After speaking with the Director of Nursing (failure to immediately physician for the use notify and inform the provided a copy of a 2/21/17 at 2:06 pm. RR of the restraint uread, in part:"Spok Representative) and	evidenced the Residents not educated on the risk and of device; or a signed or Use of Restraints. Per the ey dated 7/2015. In evidenced Resident #1 was it belt following a fall on the approximately 8:00 pm. to The resident remained at the approximately 10:00-10:30 dehab Manager went into the observed the resident was ofting to awaken the resident ed she observed the gait belt do the resident and buckled fair. The Rehab Manager do the resident to the Director office and showed her the lint was immediately removed as assessed for injury, none of investigation was initiated. The Rehab Manager do the resident was initiated. The night shift Licensed (N#1) was suspended for three	F1	57		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION G		ATE SURVEY OMPLETED
		495258	B. WING			C 02/23/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434		32 : 23: 23 : :
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 157	was the DON. In addition, the surve of a Nursing Progress 10:53 am, this note of the restraint use, read: "Late entry from (name of Physician) with the gait belt. Methis note was the DO On 2/23/17 at 10:40 Representative (RR The RR stated she was gait belt restraint but the above findings of consult the Physicia Representative immore treatment significant restraint was shared with the Administrator Vice-President of Open	ey team was provided a copy as note dated 2/22/17 at was informing the Physician 13 days after the fact and m 2/22/17 Call placed to concerning resident incident essage left." The author of DN. am, the Resident of the was contacted via phone. Was informed yesterday of the twith "very little details". of the facility staff failing to an and notify the Resident ediately for the need to alter ally with the use of a physical during a pre-exit meeting or, the DON and the Regional perations on 2/23/17.	F 1:	,		
	7/2015 is documented "Policy: Physical and initiated only after a determines that they resident's medical sy use. Definitions: Physical method or physical of material, or equipment the resident's body to remove easily which	ed "Restraints" last revised ed in part, as follows: d/or chemical restraints will be comprehensive review are necessary to treat the symptoms that warrant their all Restraint-any manual or mechanical device, ent attached or adjacent to hat the individual cannot a restricts freedom of I access to one's body.				

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	ROVIDER OR SUPPLIER			2	TREET ADDRESS, CITY, STATE, ZIP CODE 580 PRUDEN BOULEVARD UFFOLK, VA 23434	1 021	20/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 157	determine if the device freedom of movemen 2. If the device restricts a restraint. C) Physician order magnetic stype of restrement properties type of restrement poison of the restraint of the	Restraints Int Decision Tree (Form 3.40) Be restricts the residents It. Incts freedom of movement it Inust be obtained that Inust be obtained that Inust party will be educated Interest of device and sign the Inust of Restraints (Form In the state in which an is incomplete emptying of the incomplication of benigm (BPH-enlargement of the incomplete) In the state in which an incomplete emptying of the incomplete emptying empty	F	157			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING		(X3) DATE SURVEY COMPLETED			
		495258	B. WING		02/23/2017
NAME OF PROVIDER				STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434	1 02/20/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETI
Interval possible pos	sible 15 which ely cognitively decision makinum: (A.) Acute ges: the reside nattention and esident was covior is continuous. Under Selent #3 was coverson assistant sive one person assistant sive one person assistant prevents resident. Ident #3's Compared and document was and document assistant for entire that prevents resident. In American of Resident and the prevents resident and document assistant assi	Status (BIMS) was a 3 out of indicated Resident #3 was impaired and incapable of ing. Under Section C 1310 Onset Mental Status ent was coded 0 indicating no, (C.) Disorganized Thinking: ded as 1 indicating the rusly present and does not ction G Functional Status ded as requiring extensive ce for bed mobility and en assistance for transfers. Pestraints, the resident was a trunk or limb restraint or a ising had not been used on the present was nented in part, as follow: Date imitated: 4/7/16. Cushion to WC (wheelchair) shions. Date imitated:	F 15		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION		E SURVEY IPLETED
						С
		495258	B. WING _		0:	2/23/2017
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP COD	E	
				2580 PRUDEN BOULEVARD		
AUTUMN	CARE OF SUFFOLK			SUFFOLK, VA 23434		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 157	Continued From page	e 9	F 1	57		
	Interventions: *Appro Date imitated: 4/7/16	oach in a calmer manner. 3.				
	functioning character judgement, decision	ressive decline in intellectual ized by deficit in memory, making and thought process Dated Imitated: 5/17/16.				
	cues. Dated Imitated *Be patient with resid 5/17/16. *Gently redirect when	ent. Dated Imitated:				
	the potential to demo (Name) Resident #3	dent #3 continues to have nstrate physical behaviors. has a hx (history) of being Date Imitated: 2/13/17.				
	interventions in beha 2/13/16. Revision on *Modify environment comfortable, relaxed, imitated: 2/13/17. Re *Monitor/document/re of danger to self and 1/24/17. *When the resident be when necessary before Guide away from sou calmly in conversation	to make the resident more etc. as needed. Date				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING		X3) DATE SURVEY COMPLETED	
		495258	B. WING			C)2/23/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434		72.12.51.2011	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 157	On 2/21/17 at 9:15 a conducted with CNA Assistant) who works complaint the State S about a particular resulting the interview had witnessed any orestrained in the facilithe past couple of movith a gait belt. Whe around the halls. She the hallway in a where with a gait belt around that is up and down a easily." The surveyor taking care of the resulting care of the resultin	in. Revision on: 2/21/17. Im. an interview was #1 (Certified Nursing the 3-11 shift regarding a Survey Agency had received sident being restrained. In a saked if she ther residents being ity. CNA #1 stated, "Yes, in onths (Name of Resident #3) in I have a break I walk to (Resident #3) was sitting in elchair by the nurse's station do her, she is another one and becomes combative that night?" CNA #1 N #2) (Licensed Practical transked CNA #1 if restraining the factory of abuse. CNA #1 stated, stopped and reported it." The CNA #1 if she had recently the CNA #1 if she had recently the conditions in a phone interview was #3 regarding a complaint the shad received about a sting restrained. During the sasked if she had witnessed being restrained in the facility.	F 18	57			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		3) DATE SURVEY COMPLETED				
		495258	B. WING			C
NAME OF P	ROVIDER OR SUPPLIER	430230		STREET ADDRESS, CITY, STATE, ZIP	CODE	02/23/2017
	CARE OF SUFFOLK			2580 PRUDEN BOULEVARD SUFFOLK, VA 23434	0052	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 157	Continued From page	± 11	F ·	157		
	can be a violent lady. abuse to restrain a re	k, but when she is up she The surveyor asked, "Is it sident?" CNA #3 stated, or her safety, better than to				
	regarding a complaint had received about a restrained. During the asked if she had with being restrained. LPI Resident #3) about a her wheelchair. She gets real combative a The Surveyor asked, for the resident instea #2 stated, "They coulplan for interventions walking her, or toiletin asked, "Have you ever Resident #3)?" LPN:	m. an interview was #2 who works the 3-11 shift the State Survey Agency particular resident being e interview LPN #2 was essed any other residents N #2 stated, "Yes, (Name of month ago with a gait belt in is restrained quite often, she nd combative with others." "What else could have been d of restraining her?" LPN d have looked at the care like a lap-buddy, alarms, ng her." The surveyor then er restrained (Name of #2 stated, "Yes, I have a month ago with a gait belt."				
	The surveyor asked, you actually restraine stated, "It was in Januthink it was January thot enough staff to ke The surveyor asked L physician had been in that Resident #3 had order for the restraint physician. LPN #2 st doctor or get an order she was doing all I re short staffed." The survey was abuse to physician.	d the resident?" LPN #2 lary like the 9th or 24th. I he 9th because there was per my other patients safe." PN #2 if Resident #3's otified by her on January 9th been restrained and if an had been obtained from the lated, "No, I did not call the lated, "To an't remember what member is that we were larveyor asked LPN #2 if it lly restrain a resident. LPN eve it is. I didn't know what				

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F 157	Continued From pag	ue 12	F 1	57		
	else to do, you are u stuff done and under	nder pressure to get your staffed."				
	Written Employee C	file was reviewed and a counseling dated 2/16/17 was nented in part, as follows:				
		ng correction: Failure to lure concerning restraints. ent rights.				
	Disciplinary action: Written warning. Name (LPN #2) received the facilities restraint policy as well as Resident rights. Name (LPN #2) was re-educated on proper interventions for residents that are a fall risk.					
	LPN #2 refused to si Counseling.	ign the Written Employee				
	the Administrator, the and the Regional Video where the above inforced regarding Resident #2 and witnessed by DON stated, "We we	o.m. a meeting was held with the Director of Nursing (DON) the President of Operations formation was shared #3 being restrained by LPN of CNA #1 and CNA #3. The there not aware she had also we will start an investigation				
	Physician Orders for were reviewed. No	and discontinued monthly January and February 2017 Physician order was identified ntinued for the use of a t #3.				
		ation Administration Record ruary 2017 were reviewed.				

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F 157	F 157 Continued From page 13		F 1	57		
		ed that Resident #3 was PN #2 for 13 nights in January oruary.				
		's Notes 1/9/17 By LPN #2 documented in part, as				
	50 mg (milligrams)	0) p.m. Tramadol HCL Tablet Give 50 mg by mouth every 4 Pain "My knee's hurt" prn as				
	50 mg (milligrams)	3) p.m. Tramadol HCL Tablet Give 50 mg by mouth every 4 Pain PRN (as needed) Effective.				
	surveyor a copy of to (FRI) that was faxed	ty Administrator provided the he Facility Reported Incident I to the State Survey Agency #3 being physically restrained as follows:				
		gation of abuse/mistreat acluding location, and action to use of restraints.				
	Responsible party, f	otification provided to Physician, APS (Adult , DHP (Department of Health 1/17.				
	surveyor a copy of to (FRI's) that were fax of Health Profession	ty Administrator provided the he Facility Reported Incidents and to the Virginia Department has regarding Resident #3 trained documented in part,				

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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434	1 0.	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SHOOT COME ACTION SHOT COME ACTION SHOOT COME ACTION SHOOT COME ACTIO	OULD BE	(X5) COMPLETION DATE
F 157	Describe incident, intaken: Nurse restrait to a wheelchair. Name of employee in LPN #2 Employee action initithave employment teles. 2. Injuries: No Incident Type: Allegate Describe incident, intaken: LPN did not rused as a restraint on Name of employee in LPN #4 Employee action initic counseling, re-educated. 3. Injuries: No Incident Type: Allegate Describe incident, intaken: CNA did not rused as a restraint on Name of employee in CNA #3 Employee action initic counseling, re-educated. 4. Injuries: No Incident Type: Allegate Describe incident, intaken: LPN did not rused as a restraint on Incident Type: Allegate Describe incident, intaken: LPN did not rused as a restraint on Incident Type: Allegate Describe incident, incident Type: Allegate Describe Incident Type: Alle	ation of abuse/mistreat cluding location, and action ned resident with a gait belt nvolved and their position: ated or taken: Nurse will rminated. ation of abuse/mistreat cluding location, and action eport seeing a gait belt being n a resident. nvolved and their position: ated or taken: Formal ated on abuse policy. ation of abuse/mistreat cluding location, and action report seeing a gait belt being n a resident. nvolved and their position: ated or taken: Formal ated on abuse policy. ation of abuse/mistreat cluding location, and action ated or taken: Formal ated on abuse policy.	F 1	57		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495258	B. WING			C 02/23/2017
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434	<u>'</u>	02/20/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 157	o comment of the page of		F 1:	57		
		ated or taken: Formal ated on abuse policy.				
	surveyor a copy of h disciplinary actions r	egarding Resident #3 being with a gait belt which is				
	Investigation done o as a restraint on (Na	n reported use of a gait belt me of Resident #3).				
	departments: No on	ees from all shifts and e has ever seen any kind of of Resident #3) except the				
	Resident #3) with a gago. I asked if she a	I she had seen (Name of gait belt once a month or two attempted to remove it or ed that it wasn't her hall and erfere.				
		of LPN #4) had knowledge of rained but did not witness the n.				
	State Board of Nursi (Name of CNA #1): F work performance m (Name of CNA #3): F work performance m	Formal written counseling, onitoring. Formal written counseling, onitoring. Formal written counseling,				
	conducted with LPN	.m. a phone interview was #4 regarding her statement rsing that she had witnessed				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		TE SURVEY MPLETED
		495258	B. WING _			C 02/23/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434		1212312011
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 157	belt. LPN #4 was as witnessed regarding restrained. LPN #4 sesident #3) restrain was restrained with a the doorway of her rowow! I got distracted about it because I was residents too." The sto remove the restrastated, "No, I did not the time you saw her was abuse?" LPN #4 because she has fall surveyor asked, "Is president abuse and a of abuse?" LPN #4 about it and yes I'm about it and yes I'm sesident #3's Nurse 14:15 (2:15) p.m. by informing the resider being physically rest documented in part, Call placed to (Name to notify her that an extended to prevent resident from the proposition of policies and it was beof the non-compliance of opolicies and it was beof the non-compliance was also notified. (Name was also notified. (Name was also notified.)	nysically restrained with a gait sked to explain what she had Resident #3 being physically stated, "I saw (Name of ned about a month ago. She a gait belt in her wheelchair in from. I thought to myself don my own side and forgot as trying to take care of my surveyor asked, "Did you try int or report it?" LPN #4." The surveyor asked, "At restrained did you think it 4 stated, 'Well yes and no, en so many times." The ohysically restraining a are you a mandated reporter stated, "It is abuse no doubt a mandated reporter." Is Note dated 2/21/17 at the Director of Nursing ont's daughter of her mother rained by a gait belt is as follows: The of Resident #3's daughter) employee applied a gait belt from rising up out of her w/c	F 1	57		
	(Name of Resident # also notified.	3's Attending Physician) was s Note dated 2/22/17 at				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495258	B. WING			C / 23/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434		20/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 157	F 157 Continued From page 17		F 15	57		
	the resident's daught	the Administrator informing er of her mother being by a gait belt is documented				
	Contact about the fin completed by the fact restraint. Informed defound that the reside that her mother had a Informed her that stat work at the facility.	daughter, Emergency dings of the investigation ility in regards to the gait belt aughter that the investigation in was abused. Reiterated no physical injuries. If involved will no longer informed her if she had is to please contact me at				
	conducted with Resider regarding the resider with a gait belt on 1/S Physician was asked consulted with on the physically restrained Attending Physician first I heard of her be we even restrained in have expected them	e night the resident was with a gait belt. The stated, "Yesterday was the ing restrained. I didn't think esidents anymore. I would to call me if she was having lition, but I would not have				
	The facility "Code of documented in part,	Conduct" updated 11/21/16 as follows:				
	Legal Responsibilitie	s:				
		cation: All employees must e and certification laws ration of the facility.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		495258	B. WING				23/2017
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 021	23/2017
			2580 PRUDEN BOULEVARD		580 PRUDEN BOULEVARD		
AUTUMN	CARE OF SUFFOLK			s	SUFFOLK, VA 23434		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD BI TAG CROSS-REFERENCED TO THE APPROPRIA			(X5) COMPLETION DATE
	Continued From page The facility policy title Policy" last revised 2/ as follows: Policy: This facility will not to mistreatment, exploita misappropriation of re Definitions: Abuse- Includes actio infliction of injury, unrintimidation, or punish harm, pain or mental abuse, sexual abuse, abuse including abuse through the use of tec of resident property, e seclusion and injuries physical and chemica (*Willful, as used in th means the individual deliberately, not that t intended to inflict injur Restraints: (physical used per MD order ar	e 18 d "Virginia Resident Abuse 21/17 is documented in part, lerate abuse, neglect, ation of residents, and esident property by anyone. In such as the willful easonable confinement, ament with resulting physical anguish. It includes verbal physical abuse, mental e facilitated or enabled chnology, misappropriation exploitation, involuntary of unknown source, all restraints. In definition of abuse, must have acted the individual must have ry.) or chemical)-may only be and in compliance with the lines of Fall Prevention and and Procedure.	TAG		`		DATE
	f. The deployment of						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		495258	B. WING _			C 02/23/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434		2/23/2017	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 157	Continued From pag	e 19	F 1	57			
	residents, and assure that the staff assigned have knowledge of the individual residents' care needs.						
	The facility policy titled "Restraints" last revised 7/2015 is documented in part, as follows:						
	initiated only after a determines that they	nical restraints will be comprehensive review are necessary to treat the mptoms that warrant their					
	equipment attached body that the individu	cal device, material, or or adjacent to the resident's ual cannot remove easily or movement or normal					
	Procedure: Physical	Restraints					
	A) Using the Restraint Decision Tree (Form 3.40) determine if the device restricts the residents freedom of movement. 2. If the device restricts freedom of movement it is a restraint.						
	is a restraint. Before the interdisciplinary t 1. Evaluates factorisideration of the c 2. Determine the being met and the neunmet needs.	ctors leading to the device. at all the resident's needs are sed to restrain is not due to that all alternative measures					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
		495258	B. WING			C 02/23/2017	
	ROVIDER OR SUPPLIER		•	2	STREET ADDRESS, CITY, STATE, ZIP CODE 580 PRUDEN BOULEVARD SUFFOLK, VA 23434		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 157	restraint being considers. 5. Involve resider making and educated benefits. 6. Analyze all initiate is device most appropriate. What has to the resident. b. When is c. What is the d. What interested in the e. Why didned work? f. What is the g. Will it entitle? C) Physician order may specifies type of restration of the restraint on the restraint on the restraint on the restraint of the restraint of the Regional Vice-Prestre above information asked the Director of have expected for he restraining the reside stated, "I would have her, gotten her up and the properties of the reside stated, "I would have her, gotten her up and the properties of the content of the reside stated, "I would have her, gotten her up and the properties of the reside stated, "I would have her, gotten her up and the properties of the reside stated, "I would have her, gotten her up and the properties of the	sks versus benefits of the lered. ent and family in decision those regarding risks and formation and decide which priate. Is happened/or is happening the need occurring? The cause? Enventions have been tried? It previous interventions The least restrictive device? The nance resident's quality of the least restrictive device?	F	157			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495258	B. WING _				C 23/2017
	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE D PRUDEN BOULEVARD	<u> </u>	23/2017
AUTUMN	CARE OF SUFFOLK			SUFFOLK, VA 23434			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
F 157	The Regional Vice-Pr stated, "We are not have sidents were treated move forward from he information was shared (1) Psychosis: any morganic or emotional or emotio	to take it off and report it." resident of Operations appy with the way the dat all. All we can do is ere." Prior to exit no further ed. rajor mental disorder of origin characterized by a reality testing, in which the revaluates the accuracy of and thoughts and makes about external reality, even revidence. ressive organic mental dby chronic personality ion, disorientation, stupor, retual capacity and function, entrol of memory, judgement, on the proportion to reality. resented from Mosby's e, Nursing, and Health	F	157			
F 221 SS=E	This is a COMPLAINT RIGHT TO BE FREE RESTRAINTS CFR(s): 483.10(e)(1), §483.10(e) Respect a	FROM PHYSICAL 483.12(a)(2)	F:	221			3/17/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495258	B. WING_		1	C / 23/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434	02	23/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 221	Continued From pag	e 22	F 2	21		
	and dignity, including §483.10(e)(1) The rig physical or chemical purposes of disciplin	ght to be treated with respect g: ght to be free from any restraints imposed for e or convenience, and not resident's medical symptoms,				
	neglect, misappropri and exploitation as d includes but is not lir corporal punishment	right to be free from abuse, ation of resident property, lefined in this subpart. This nited to freedom from , involuntary seclusion and nical restraint not required to				
	or chemical restraint discipline or conveni required to treat the symptoms. When the	esident is free from physical s imposed for purposes of ence and that are not resident's medical				
	alternative for the lead document ongoing restraints. This REQUIREMEN by: Based on staff intenfacility document revalued a complaint investigation of the staff o	ast amount of time and e-evaluation of the need for T is not met as evidenced views, clinical record review, iew and during the course of ation the facility staff failed to ents in the survey sample, were treated with respect or maintain his/her highest g in an environment that		F-221 1. Res. # 1 & 3 were phexamined to ensure no physical is being used. 2. All residents are at risk for issue. 3.A In-service for all departs on Resident S Rights and americal service for all departs on Resident S Rights and americal service for service for all departs on Resident S Rights and americal service for service f	restraint or this artments	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495258	B. WING			C 02/23/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434	'	V 2 3 3 3 3 3 3 3 3 3 3
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX			(X5) COMPLETION DATE
F 221	convenience, and no resident's medical sy. The State Survey Ag anonymous complair alleged a resident har restrained all day an identified in the complete of the conducted by this St found that the facility restraint (a gait belt) convenience for two #3). 1. The facility staff far #1 was treated with the right to be free frogait belt imposed on purpose of staff convenience for two purpose of staff convenience for two the right to be free frogait belt imposed on purpose of staff convenience for two hours. 2. The facility staff far #3 was treated with the right to be free frogait belt imposed on purpose of staff convenience for two facility on 12/23/16 and following a short hos through 1/4/17 for according to the state of t	physical restraints for at required to treat the amptoms. ency received an and on February 15, 2017 that ad been left in a chair dovernight. The resident plaint was Resident #1. Implaint investigation at Survey Agency it was a staff imposed a physical for purposes of staff residents (Residents #1 and diled to ensure that Resident dignity and respect to include form a physical restraint of a February 9, 2017 for the venience for approximately diled to ensure that Resident dignity and respect to include form a physical restraint of a physical restraint of a January 9th, 2017 for the venience. d: Driginally admitted to the and readmitted on 1/4/17 pital stay from 12/28/16 state urinary retention (1). BPH (benign prostatic	F 22	Abuse and Prevention Policy to being free from abuse and rebet be treated with dignity and resolute 3. B Facility implemented a audit/exam of monitor that no presidents 5 x per week to restrause. 4 A. During resident council, rebe asked if they have any concregarding being treated with digrespect. 4 B Audits noted above will of M-F randomly on all shifts for the days. 4 C Audit results shared in QAPI meetings. It will determined at the QAPI meeting audits are to continue past 60 of 5. 3/17/17	estraints spect physical physical aints are in esidents will eerns gnity and/or continue ne next 60 s will be ill be gg if the	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495258	B. WING _			C 02/23/2017
	ROVIDER OR SUPPLIER CARE OF SUFFOLK	1		STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434	<u> </u>	02/20/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 221	with an assessment 1/31/17 coded the repossible 15 on the B Mental Status), indices severely impaired dather resident was condisorganized thinking any behaviors. The resident was concorridor on the unit we staff. Mobility devices wheelchair. The residender drainage. Under the since Admission/Enther Assessment. This were cord and the compact Centered Plan of Cathad a fall on 1/8/17 of the Resident Center 12/24/16 evidenced at risk for falls/impair confusion related to vision related to vision related to glaulicers and debility. 12/9/17. The goal was an injury due to a fall Interventions listed to safety did not include restraint. The facility process of evaluation using a physical restraint. The facility all tour of the facility all	reference date (ARD) of resident as scoring a 3 out of a all MS (Brief Interview for rating the resident had ally decision making skills. It ded as having inattention and g. The resident did not exhibit resident was able to walk a his/her room and in the with limited assistance of one as used were a walker and dent had a Foley catheter for onder Section J. 1800 Fall sident as not having any falls ary or Reentry or Prior ras inaccurate as the clinical prehensive Resident re evidenced the resident which is prior to the ARD. The resident was identified as red safety related to Alzheimer's dementia, poor as the resident will not sustain a through review. The review of the prevent falls and promote as the use of a physical of and care planning prior to	F2	221		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED		
		495258	B. WING			C 2/23/2017	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434			02/23/2017	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 221	LPN #3) working on Resident #1's room at 3:00 am. She wa any allegations of a restrained to a whee (name of Resident # circumstances for th stated, "He had falle shift), when I arrived onit was buckled behind the nurses st stayed up all night (a would be asked if he bedhe was alert w did not try to fight the restraint was not sight out of mind". CNA (Certified Nurse the resident to remo resident to bed at ap LPN #3 was asked in initiated the gait belt she repeated that it resident by the 3-11 exactly who placed to When asked as a Mishould you have dor "Report it to the DOI LPN#3 stated she w (2/10/17-2/12/17), in the abuse and restraint was not sight out of mind".	Licensed Practical Nurse/ In the East unit where was located was interviewed is asked if she was aware of resident having been elchair. She stated, "Yes, et)". She was asked about the ele use of the restraint. She in earlier in the shift (3-11 pm it to work he had a gait belt reshind the wheelchair, he was ration in the wheelchair, he is nurses station), periodically is wanted to go back to restraint. When asked why removed, she stated, "Out of She stated she had asked the ele Aide/CNA#3) assigned to restraint she stated, "No", had been placed on the shift, she did not know the restraint on the resident. andated Reporter what he? Her response was N (Director of Nursing)". as suspended for three days serviced and given a copy of	F 2:	21			
	wheelchair; therefore remove at will, which	ckled in the back of the e, the resident could not nestricted freedom of failed to remove the gait belt,					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG	· ,	(X3) DATE SURVEY COMPLETED	
		495258	B. WING			C 2/23/2017	
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CO 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434		212312017	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 221	abuse to the DON. On 2/21/17 at 3:20 at (DON) was interview Resident #1 being muthile in the DON's provided with a copyreport of this allegat noted Resident #1 "restraining him to the if the Physician and were notified by the used to restrain Resident had been says as the pool of the DON was asked incident) had been says as there was staff failed to follow. The DON stated shorestraint when the Resident to her office 2/10/17. The reside waist that was buckly wheelchair. The investigation reseven (7) staff who and the night shift of the Licensed Practical 1. 11-7 pm night shift of the Licensed Practical 1. 11-11-11-11-11-11-11-11-11-11-11-11-11-	ge 26 use, and failed to report the am, the Director of Nursing wed about the allegation of estrained with a gait belt. office this surveyor was y of a facility's investigation ion dated 2/10/17. This report was found with a gait belt e chair". The DON was asked the Resident Representative facility that a gait belt was ident #1, she stated, "No". d if a FRI (Facility Reportable sent to the State Survey tent. She stated, "No". Her he did not consider this "no harm". She stated the the facility's restraint policy. was made aware of the tenab Director wheeled the tenab Director wheele	F2	221			

	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE COMP	SURVEY LETED			
		495258	B. WING				23/2017
	ROVIDER OR SUPPLIER CARE OF SUFFOLK		1	2	STREET ADDRESS, CITY, STATE, ZIP CODE 580 PRUDEN BOULEVARD SUFFOLK, VA 23434		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 221	the nurse (LPN#1) lo resident had a fall at there was anything we resident from falling. 4 aides (CNAs-Certif 3. 3-11 pm LPN #1 (a #1)- She said that (LI him and that since shong as (LPN#2) she She wanted to keep there was so much poor The CNA interviews were as follows: 4. 3-11 pm CNA #1 as aid the resident slid often was up and dook now about the gait to She knew it was wro saying anything to the was not agitated or up 5. 11-7 pm CNA- She information r/t (relate 6. 7-3 am CNA assig 2/10/17- She had not spoken because he held to been in the chair who she did not notice ar 7. RN Supervisor 3-1 about the fall but did On 2/21/17 at 4:00 a interviewed. He state DON to do the invest were disciplined, writ re-education, and instated the facility was in we don't use them	She said Yes she had helped cate a gait belt after the 8 pm. She did not think grong with keeping the She stated there were only ited Nurse Aides). Assigned to care for Resident PN#2) put the gait belt on the hadn't been a nurse as didn't think anything about it. Thim from falling again since aperwork with a fall. By the DON investigation ssigned to Resident #1: She from his bed and that he with in his room. She did belt the nurses put on him. The but was uncomfortable to charge nurse. The resident incomfortable. The resident on the done any care on him when the done any care on him when the done any care on the shift. By gait belt in place. In pm-Stated she only knew not know about the gait belt. The Administrator was the done involved.	F	221			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	495258	B. WING		C 02/23/2017	
OVIDER OR SUPPLIER		2	580 PRUDEN BOULEVARD	1 02/20/2017	
(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD) BE COMPLETION	
for a restraint abuse considered it not fol use". When asked Survey Agency he sho injury involved' staff involved with the straint were reported for a procedural is the Rehab Manage at 7:00 am. She state was a procedural is the Rehab Manage at 7:00 am. She state wheelchair. She state wheelchair. She state wheelchair. She state wheelchair she stated to the back of lattached to him I pure officehe was dress when asked about the straint she stated to econsidered a restraint she stated to want him up and do (restraint) policyI of the state mplemented other increase supervisions oilleting, and pain". An incident report do me by LPN #1 notes	e?" He stated, "Abuse, no, we lowing procedure for gait belt if a FRI was sent to the State stated, "No, because there is ". When asked if any of the ne application of the gait belt ted to the Board of Health ed, "No, I did not report itit sue". The was interviewed on 2/21/17 ated she was walking past the I noted he was asleep in the sted, "I noticed he fell asleep in t's when I noticed the (gait) his chair, when I saw it was ashed him to the DON's sedhe did not smell fresh". That is not policyit would straintnot a form of keep him safethey didn't follow don't consider it abuse no harm". She stated the dimmediately removed as on, checking on needs such as stated 2/9/17 entered at 8:05 different was observed.	F 221			
	SUMMARY'S (EACH DEFICIEN REGULATORY OF Continued From particles of a restraint abuse on sidered it not follows. When asked of survey Agency he statement of the straint were reported as a procedural is of the Rehab Manage of th	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 28 or a restraint abuse?" He stated, "Abuse, no, we considered it not following procedure for gait belt use". When asked if a FRI was sent to the State Survey Agency he stated, "No, because there is no injury involved". When asked if any of the staff involved with the application of the gait belt esteraint were reported to the Board of Health Professions he stated, "No, I did not report itit was a procedural issue". The Rehab Manager was interviewed on 2/21/17 at 7:00 am. She stated she was walking past the esident's room and noted he was asleep in the wheelchair. She stated, "I noticed he fell asleep in his wheelchairthat's when I noticed the (gait) well on the back of his chair, when I saw it was attached to him I pushed him to the DON's officehe was dressedhe did not smell fresh". When asked about the use of the gait belt for a estraint she stated, "That is not policyit would be considered a restraintnot a form of abusewe need to keep him safethey didn't want him up and downthey didn't follow restraint) policyI don't consider it abuse because there was no harm". She stated the DON was upset and immediately removed the gait belt. She stated the staff could have increase supervision, checking on needs such as oileting, and pain". An incident report dated 2/9/17 entered at 8:05 om by LPN #1 noted Resident #1 was observed	ARE OF SUFFOLK SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 28 or a restraint abuse?" He stated, "Abuse, no, we considered it not following procedure for gait belt isse". When asked if a FRI was sent to the State Survey Agency he stated, "No, because there is no injury involved". When asked if any of the staff involved with the application of the gait belt estraint were reported to the Board of Health Professions he stated, "No, I did not report itit was a procedural issue". The Rehab Manager was interviewed on 2/21/17 at 7:00 am. She stated she was walking past the esident's room and noted he was asleep in the wheelchairthat's when I noticed the (gait) belt on the back of his chair, when I saw it was attached to him I pushed him to the DON's officehe was dressedhe did not smell fresh". When asked about the use of the gait belt for a estraint she stated, "That is not policyit would be considered a restraintnot a form of abusewe need to keep him safethey didn't want him up and downthey didn't follow restraint) policyI don't consider it abuse because there was no harm". She stated the DON was upset and immediately removed the gait belt. She stated the staff could have mplemented other interventions such as increase supervision, checking on needs such as oileting, and pain". An incident report dated 2/9/17 entered at 8:05	ARE OF SUPFLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY) Continued From page 28 or a restraint abuse?" He stated, "Abuse, no, we considered it not following procedure for gait belt use?". When asked if a FRI was sent to the State Survey Agency he stated, "No, because there is no injury involved" When asked if any of the statfinvolved with the application of the gait belt estraint were reported to the Board of Health Professions he stated, "No, I did not report it! twas a procedural issue". The Rehab Manager was interviewed on 2/21/17 at 7:00 am. She stated she was walking past the esident's room and noted he was asleep in the wheelchairsha's when I noticed the (gait) belt on the back of his chair, when I saw it was attached to him I pushed him to the DON's fifticehe was dressedhe did not smell fresh". When asked about the use of the gait belt for a estraint she stated, "That is not policyit would be considered a restraintnot a form of bibusewe need to keep him safethey didn't want him up and downthey didn't follow restrainty policyI don't consider it abuse because there was no harm". She stated the 20N was upset and immediately removed the gait belt. She stated the staff could have mplemented other interventions such as increase supervision, checking on needs such as olieting, and pain". An incident report dated 2/9/17 entered at 8:05 mb by LPN #1 noted Resident #1 was observed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495258	B. WING _			C 02/23/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434	<u> </u>	02/23/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 221	confused. The Physician was of 2/21/17 at 11:00 amounthe facility had called the resident, his responsible to the resident, his responsible to the resident, his responsible to the resident was notified that Responsible to the restrained with a gain notification of a fall of did not notify me(howes to me". When expected them (facility had been made awarestrained, he responsible to the resident was observed in his room in a wheelchair watcomes a gait belt to reflect the stated, "Yes". Further incident was met with nonsensical, saying and then long pause responses. Resident #1 was responsible to the approximately 8:00 pat the nurses station all night. Fourteen her	ontacted via phone on The Physician was asked if I to obtain an order to restrain conse was, "No, no one has about restraintswhoever core?"When asked if he sident #1 was physically it belt in a wheelchair after in 2/9/17, he stated, "They im/her) being restrained is asked, "Would you have ty) to inform you after they are the resident was in bed, in the activities room hing TV; there was no in bed, in the activities room hing TV; there was no in bed, in the staff had ever strain him to the wheelchair, arther questioning of the in the resident speaking "Are you here for thethe" is followed with inappropriate trained with a gait belt are evening of 2/9/17 at om. The resident remained restrained with the gait belt burs later, at approximately	F2	221		
	and then long pause responses. Resident #1 was res following a fall on the approximately 8:00 pat the nurses station all night. Fourteen he 10:00-10:30 am on 2 noted the gait belt re	s followed with inappropriate trained with a gait belt e evening of 2/9/17 at om. The resident remained restrained with the gait belt				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	PLE CONSTRUCTION G	` ′	(X3) DATE SURVEY COMPLETED		
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	CARE OF SUFFOLK			STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434		1 02/20/2017	
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F 221	The restraint was im resident was assess found. A facility investige evidenced the restrato prevent movement symptom. The clinical record a Resident Centered Facility failed to follow evaluation and care physical restraint. The clinical record e Representative was benefits of (restraint) Informed Consent for The Physician Order Completed, Discontithrough 2/28/17 was physician order(s) for restraint, type of rest duration of the restrapolicy dated 7/2015. The facility failed to fand dignity to attain practicable well-bein prohibited the use of convenience, and no resident's medical sy was conducted with	and showed her the restraint. In mediately removed and the led for injury, none was restigation was initiated. In the comprehensive Plan of Care evidenced the led a systematic process of planning prior to using a In the comprehensive Plan of Care evidenced the led a systematic process of planning prior to using a In the ducated on the risk and led device; or a signed led ur Use of Restraints. In Summary Report for Active, In the application of a physical led traint, reason for use or the led the the facility restraint In the application of a physical led traint, reason for use or the led the the facility restraint In the application of a physical led traint, reason for use or the led the the facility restraint In the application of a physical led traint, reason for use or the led the the facility restraint In the application of a physical led traint, reason for use or the led the the the the led th	F 2	21			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495258	B. WING		C 02/23/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434	02/23/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE COMPLETION
F 221	the above information asked, "Is restraining issue with the reason DON responded," Redignity issue with the concept". "It was inal on as a restraint." The "What is it meant to be respect" The Administrator stated, happen." The Region Operations stated, "Way the residents we do is move forward for further information was Facility Policies and Follows: 1). The policy titled "Follows: 1). The p	esident of Operations where a was shared. Surveyor #2 with a gait belt a dignity able person concept? The straining with a gait belt is a reasonable person oppropriate to have a gait belt e Administrator was asked, the treated with dignity and strator stated, "How You sted." The surveyor then the residents failed?" The "By allowing all of this to nal Vice-President of We are not happy with the retreated at all. All we can om here." Prior to exit not as shared. Procedures reviewed are as Resident Rights and Facility revised 11/16 is as follows: By's policy to abide by all to communicate these rights designated representatives by can understand. The resident has a right be, self-determination, and and access to persons and sutside the facility, including a section. Beet, and Quality of Life: a h resident with respect and acch resident in a manner	F 2:	21	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 221	of life, recognizing e The facility must pro the resident. (e) Respect and Dig (1) Restraints: physical or chemica purposes if discipline required to treat the symptoms, consiste 2). The facility policy revised 7/2015 is do Policy: Physical and initiated only after a determines that they	ancement of his or her quality ach resident's individuality. tect and promote the rights of gnity: The right to be free from any restraints imposed for ed or convenience, and not resident's medical	F 221			
	method or physical of material, or equipment the resident's body to remove easily which movement or normal Procedure: Physical A) Using the Restrated etermine if the device restraint of the device restraint. B) If the device restraint is a restraint. Before the interdisciplinary 1. Evaluates faconsideration of the 2. Determine the	int Decision Tree (Form 3.40) ice restricts the residents nt. ricts freedom of movement it icts freedom of movement it e proceeding with the device team: ctors leading to the				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 221	have been attempted unsuccessful. 4. Weighs the ristrestraint being considers. 5. Involve resider making and educated benefits. 6. Analyze all initiate device most appropriate a. What has to the resident. b. When is c. What is the d. What is the d. What is the d. What is the g. Will it enlife? C) Physician order may be of restrained to the resident of the restrained on risk and benefits of the informed Consent for 3.41). Definition: (1) Urinary retention: not emptying properly complication of bening (BPH). Mosby's Dictionary of Health Professions 88.	nat all alternative measures and found to be sks versus benefits of the lered. Ent and family in decision those regarding risks and formation and decide which priate. It is happened/or is happening the need occurring? The cause? Enventions have been tried? The previous interventions are least restrictive device? The nance resident's quality of the stant, reason for use, and the sint. The insible party will be educated of device and sign the trust of Restraints (Form the stant). A side effect of the bladder of the stant of the prostatic hyperplasia.	F	2221			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 221	Disorder (3). The most recent Min assessment was a C Reference Date (AR Interview for Mental a possible 15 which severely cognitively daily decision making Delirium: (A.) Acute Changes: the resider (B.) Inattention and the resident was cod behavior is continuous fluctuate. Under Sec Resident #3 was coo two person assistants.	imum Data Set (MDS) tuarterly with an Assessment D) of 1/16/17. The Brief Status (BIMS) was a 3 out of indicated Resident #3 was mpaired and incapable of g. Under Section C 1310	F 221		
	Under Section P Rescoded a 0 indicating chair that prevents rithe resident. Resident #3's Compreviewed and docum Focus: (Name of Refalls/impaired safety. Revision: on 2/21/17 Interventions: *1/18/17 Anti thrust owith bilateral leg cus 1/18/17. Revision or *11/1/16 Bed sensor mattress, fall mat, do	straints, the resident was a trunk or limb restraint or a sing had not been used on rehensive Plan of Care was ented in part, as follows: sident #3) is at risk for Date imitated: 4/7/16. cushion to WC (wheelchair) hions. Date imitated: n: 2/21/17. chair sensor, concave for alarm, drop seat in the din lowest position. Date			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495258	B. WING		02/23/2017
	ROVIDER OR SUPPLIER CARE OF SUFFOLK			STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434	, 02:20:10
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F 221	Continued From pa	ge 35	F 22	1	
	Cognition and conti	esident #3) has Altered nues to have the potential for to) DX (diagnosis) of tated: 4/7/16. Revision			
	Interventions: *App Date imitated: 4/7/	roach in a calmer manner. 16.			
	functioning character judgement, decision	ogressive decline in intellectual erized by deficit in memory, in making and thought process i. Dated Imitated: 5/17/16.			
	cues. Dated Imitate *Be patient with res 5/17/16. *Gently redirect who inappropriate action	ident. Dated Imitated: en resident makes as. Dated Imitated: 5/17/16.			
	the potential to dem (Name of Resident	esident #3) continues to have nonstrate physical behaviors. #3) has a hx (history) of th staff. Date Imitated: on: 2/21/17.			
	interventions in beh 2/13/16. Revision of *Modify environmer comfortable, relaxe imitated: 2/13/17. *Monitor/document/	ed behavior and attempted avior log. Date imitated: on: 2/13/16. In to make the resident more d, etc. as needed. Date Revision on: 2/13/17. Ireport to MD (medical doctor) d others. Date imitated:			

_ ` · · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434	<u> </u>	02/23/2017	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 221	when necessary be Guide away from so calmly in conversat staff to walk calmly Date imitated: 2/13 On 2/21/17 at 4:00 conducted with the asked if restraining a form of abuse. Twe consider it not fouse." On 2/21/17 at 9:15 conducted with CN. Assistant) who work complaint the Office Certification had reresident being restr CNA #1 was asked other residents being CNA #1 stated, "Ye months (Name of F. When I have a breast She (Resident #3) wheelchair by the maround her, she is a down and becomes surveyor asked, "Wof the resident that "(Name of LPN #2) The surveyor asked resident was a form "Yes, I should have surveyor then asked staff to walk the surveyor then asked staff to walk the surveyor then asked surveyor then asked staff to walk the surveyor then asked staff to walk the surveyor then asked the surveyor then asked the walk the surveyor then asked the surveyor then asked the walk the surveyor then asked the surveyor th	becomes agitated: intervene agitation escalates; burce of distress; Engage ion; If response is aggressive, away, and approach later. 3/17. Revision on: 2/21/17. a.m. an interview was Administrator and he was a resident with a gait belt was the Administrator stated, "No, collowing procedure for gait belt on the state of the stat	F 22	21			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	10020		STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434	02/23/2017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION		
F 221	conducted with the shift supervisor who the facility and if reconsidered abuse. stated, "We are andepends on the resto harm himself, or restraining a reside On 2/21/17 at 2:15 conducted with CN. State Survey Agence particular residents interview CNA #3 wany other residents CNA #3 stated, "(N. sometimes with a galways short and sl when was the last to restrained. CNA #3 two and once in a beye on her while we	a.m. an interview was RN (Registered Nurse) 3-11 o was asked about restraints in straining a resident was The RN 3-11 Supervisor o restraint facility and it sident. If the resident is trying slapping their face its not but ent for convenience is abuse." p.m. a phone interview was A #3 regarding a complaint the cy had received about a being restrained. During the was asked if she had witnessed being restrained in the facility. ame of Resident #3) eait belt because we are the falls." The surveyor asked dime she saw Resident #3 B stated. "In the last month or olue moon. We can't keep an the are changing people. When to k, but when she is up she	F 23	,			
	can be a violent lad abuse to restrain a "For me it's not, it is bust their head ope On 2/21/17 at 2:50 conducted with LPN regarding a compla had received about restrained. During asked if she had wi being restrained. L Resident #3) about	ly. The surveyor asked, "Is it resident?" CNA #3 stated, s for her safety, better than to					

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		495258	B. WING _			C)2/23/2017	
	NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF SUFFOLK			STREET ADDRESS, CITY, STATE, ZIP COL 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434		7212012011	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 221	The Surveyor asked, for the resident instead for the resident instead #2 stated, "They couplan for interventions walking her, or toileti asked, "Have you ev Resident #3)?" LPN restrained her about The surveyor asked, you actually restrained stated, "It was in Jan think it was January in not enough staff to keep to the surveyor asked physician had been restrained the physician. LPN #2 stated and order for the restrained physician. LPN #2 stated. "The swas abuse to physician was abuse to physician #2 stated, "I don't be else to do, you are unstuff done and under LPN #2 's employee Written Employee Colidentified and docum Actions encompassing follow proper procedured the well as Resident right well as Resident right.	and combative with others." "What else could have been ad of restraining her?" LPN id have looked at the care like a lap-buddy, alarms, ang her." The surveyor then er restrained (Name of #2 stated, "Yes, I have a month ago with a gait belt." "Do you remember what day ad the resident?" LPN #2 uary like the 9th or 24th. I the 9th because there was been my other patients safe." LPN #2 if Resident #3's notified by her on January 9th been restrained and if an at had been obtained from the stated, "No, I did not call the r. I can't remember what the emember is that we were urveyor asked LPN #2 if it ally restrain a resident. LPN lieve it is. I didn't know what ander pressure to get your staffed." file was reviewed and a punseling dated 2/16/17 was ented in part, as follows:	F 2	21			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·			(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434	!	02/20/2011		
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F 221	Counseling. On 2/21/17 at 3:15 the Administrator, the Administrator of the Administrato	p.m. a meeting was held with the Director of Nursing (DON) rice President of Operations formation was shared #3 being restrained by LPN by CNA #1 and CNA #3. The were not aware she had also downwill start an investigation of Physician order was identified ontinued for the use of a not #3. cation Administration Record bruary 2017 were reviewed. Red that Resident #3 was PN #2 for 13 nights in January	F 22	21				
	hours as needed for needed. 1/9/17 at 20:03 (8:0 50 mg (milligrams)	Give 50 mg by mouth every 4 or Pain "My knee's hurt" prn as 03) p.m. Tramadol HCL Tablet Give 50 mg by mouth every 4 or Pain PRN (as needed)						

', '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434		02/23/2017		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 221	surveyor a copy of t (FRI) that was faxed Health Office of Lice regarding Resident documented in part. Injuries: No Incident Type: Alleg Describe incident, in taken: Inappropriate If applicable, date n Responsible party, Protective Services: Professionals): all 2 On 2/22/17 the facil surveyor a copy of t (FRIs) that were fax of Health Profession being physically resus follows: 1. Injuries: No Incident Type: Alleg Describe incident, in taken: Nurse restrato a wheelchair. Name of employee LPN #2	ity Administrator provided the he Facility Reported Incident of to the Virginia Department of ensure and Certification #3 being physically restrained as follows: gation of abuse/mistreat including location, and action is use of restraints. otification provided to Physician, APS (Adult in DHP (Department of Health)	F 2	21				
		erminated. gation of abuse/mistreat ncluding location, and action						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		495258	B. WING			C 02/23/2017		
	ROVIDER OR SUPPLIER CARE OF SUFFOLK		-	ST 25	REET ADDRESS, CITY, STATE, ZIP CODE 80 PRUDEN BOULEVARD UFFOLK, VA 23434	<u> U2/</u>	23/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 221	used as a restraint or Name of employee in LPN #4 Employee action initial counseling, re-educard 3. Injuries: No Incident Type: Allegate Describe incident, incident: CNA did not roused as a restraint or Name of employee in CNA #3 Employee action initial counseling, re-educard 4. Injuries: No Incident Type: Allegate Describe incident, incident Type: Allegate Describe incident, incident: LPN did not roused as a restraint or Name of employee in LPN #1 Employee action initial counseling, re-educard On 2/22/17 the Direct surveyor a copy of hed disciplinary actions rephysically restrained documented in part, and Investigation done on as a restraint on Name Spoke to 44 employed departments: No one	eport seeing a gait belt being a resident. volved and their position: ated or taken: Formal ted on abuse policy. Ation of abuse/mistreat aluding location, and action a resident. volved and their position: ated or taken: Formal ted on abuse policy. Ation of abuse/mistreat aluding location, and action abuse policy. Ation of abuse/mistreat aluding location, and action apport seeing a gait belt being a resident. volved and their position: ated or taken: Formal ted on abuse policy. Ation of Nursing provided the are investigation and apparding Resident #3 being with a gait belt which is as follows: areported use of a gait belt te (Resident #3).	F	221				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G	(X3)	(X3) DATE SURVEY COMPLETED		
		495258	B. WING		C 02/22/2047		
	ROVIDER OR SUPPLIER	700200		STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434	- 1	02/23/2017	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 221	Resident #3) with a ago. I asked if she report it and she sta she didn't want to in Conclusion: (Name a resident being restraint being put of the CNA #1): Work performance in (Name of CNA #1): work performance in (Name of LPN #4): work performance in (Name of	stated she had seen (Name of a gait belt once a month or two attempted to remove it or ated that it wasn't her hall and nterfere. e of LPN #4) had knowledge of strained but did not witness the bon. suspended, reported to the sing, termination. Formal written counseling, monitoring. Formal written counseling, monitoring. Formal written counseling,	F 2				
	about it because I v residents too." The to remove the restri stated, "No, I did no the time you saw ho was abuse?" LPN	was trying to take care of my e surveyor asked, "Did you try aint or report it?" LPN #4 ot." The surveyor asked, "At er restrained did you think it #4 stated, 'Well yes and no, allen so many times." The					

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		495258	B. WING		02/23/2017		
	ROVIDER OR SUPPLIER CARE OF SUFFOLK			STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434	, , , , , , , , , , , , , , , , , , , ,		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE COMPLETION		
F 221	resident abuse and of abuse?" LPN #4 about it and yes I'm Resident #3's Nurse 14:15(2:15) p.m. by informing the reside being physically resident in part Call placed to (Nam to notify her that an to prevent resident and falling. I explain non-compliance of policies and it was a of the non-complian was also notified. (daughter) did not had (Name of Resident also notified. Resident #3's Nurse 15:48 (3:48) p.m. by the resident's daugh physically restrained in part, as follows: "Spoke with resident Contact about the ficompleted by the farestraint. Informed found that the resident that her mother had Informed her that st work at the facility.	physically restraining a are you a mandated reporter stated, "It is abuse no doubt a mandated reporter." e's Note dated 2/21/17 at the Director of Nursing ent's daughter of her mother strained by a gait belt is as follows: the of Resident #3's daughter) employee applied a gait belt from rising up out of her w/c	F 22				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED		
		495258	B. WING			C 2/23/2017	
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434	<u> </u>	2/23/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 221	Continued From pag	ge 44	F 22	21			
	conducted with Resiregarding the reside with a gait belt on 1/2 Physician was asked consulted with on the physically restrained Attending Physician first I heard of her bewe even restrained rhave expected them a change in her congiven an order for a The facility "Code of documented in part, Legal Responsibilities Fraud and Abuse: A fraud and abuse issureport it to their supercomfortable reporting supervisor, the empl Chief Compliance O Licensure and Certif comply with licensurapplicable to the open The facility policy tith Policy" last revised 2 as follows: Policy: This facility will not to mistreatment, exploid	Conduct" updated 11/21/16 as follows: es: Any employee who suspects a ue is required to promptly ervisor. If the employee is not g the issue to their oyee may report it to the fficer. ication: All employees must e and certification laws					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	COMPLETED		
		495258	B. WING		C	,	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434	02/23/2017		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLE	TION	
F 221	Continued From pag	e 45	F 2	21			
	Definitions:						
	infliction of injury, un intimidation, or punis harm, pain or mental abuse, sexual abuse abuse including abus through the use of te of resident property, seclusion and injurie physical and chemical (*Willful, as used in the means the individual deliberately, not that intended to inflict injuried Restraints: (physical used per MD order a	his definition of abuse, must have acted the individual must have ury.) or chemical)-may only be nd in compliance with elines of Fall Prevention and					
	Procedure:						
	3) Prevention and Ide	entification					
	sufficient numbers to residents, and assur- knowledge of the ind	f staff on each shift in meet the needs of the e that the staff assigned have ividual residents' care needs.					
	_	nical restraints will be					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG	, ,	(X3) DATE SURVEY COMPLETED	
		495258	B. WING_			C 02/23/2017
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434	I	02/23/2017
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 221	Continued From pag		F 2	21		
	determines that they	comprehensive review are necessary to treat the mptoms that warrant their				
	physical or mechanic equipment attached body that the individu	ny manual method or cal device, material, or or adjacent to the resident's ual cannot remove easily om of movement or normal				
	Procedure: Physical	Restraints				
	determine if the devi- freedom of movemen	restricts freedom of				
	is a restraint. Before the interdisciplinary to the interdisciplinary to 1. Evaluates factorisideration of the 2. Determine the being met and the neumet needs. 3. Determines the have been attempted unsuccessful. 4. Weighs the restraint being consideration of the consideration of	ctors leading to the device. at all the resident's needs are seed to restrain is not due to that all alternative measures d and found to be lisks versus benefits of the dered. ent and family in decision those regarding risks and				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495258		B. WING		C 02/23/2017	
	ROVIDER OR SUPPLIER			2	STREET ADDRESS, CITY, STATE, ZIP CODE 580 PRUDEN BOULEVARD SUFFOLK, VA 23434	1 02/	23/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 221	to the resident. b. When is a c. What is the d. What interest the e. Why didrect work? f. What is the g. Will it entitle? C) Physician order magnerifies type of restrect duration of the restraint D) Resident's responson risk and benefits of Informed Consent for 3.41). The facility policy title Facility Responsibilitied documented in part, and the resident rights, and to to residents and their in a language that the services inside and of those specified in this (1) Dignity, Responsibility as ervices inside and of those specified in this (1) Dignity, Responsibility must treat each distribution with a service inside and of those specified in this (1) Dignity, Responsibility must treat each distribution with a service inside and of those specified in this (1) Dignity, Responsibility must treat each distribution with a service inside and of the service inside and	the need occurring? The cause? The revious interventions The least restrictive device? The resident's quality of The cause resident's quality of The least restrictive device? The least resident's quality of The least resident for use, and the least resident Rights and less' last revised 11/16 is less follows: The resident has a right resident with respect and access to persons and resident with respect and ach resident in a manner	F	221			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	' '	(X3) DATE SURVEY COMPLETED	
		495258	B. WING _			C 02/23/2017
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434		02/23/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 221 Continued From page 48 maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of		F 2	221			
	physical or chemical purposes if discipling required to treat the symptoms, consisted On 2/23/17 at 3:20 pwas conducted with Director of Nursing, the Regional Vice-Pithe above information asked the Administrator or physically restrain without injury or harm Administrator stated through the process abuse policy it is corn Director of Nursing vexpected her staff to reporters when they The Director of Nursing with a gather reasonable persimappropriate to have The surveyor asked she would have expensed of restraining of Nursing stated, "I redirect her, gotten in document her behaves taff see someone report it." The Administrator treatment of the surveyor asked she would have expensed of restraining of Nursing stated, "I redirect her, gotten in document her behaves taff see someone report it." The Administrator is discovered in the surveyor asked she would have expensed of restraining of Nursing stated, "I redirect her, gotten in document her behaves the surveyor it." The Administrator is discovered in the surveyor asked she would have expensed to the surveyor asked the sur	The right to be free from any restraints imposed for ed or convenience, and not resident's medical at with 483.12(a)(2). I.m. a pre-exit conference the Administrator, the the Compliance Nurse, and resident of Operations where in was shared. The surveyor ator if a resident is chemically led to prevent movement in, is this abuse. The prevent is this abuse. The prevent is and rewriting the insidered abuse." The vas asked if she would have come forward as mandated saw Resident #3 restrained. In ing stated, "Yes, absolutely.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495258	B. WING_			C 02/23/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434	E	02/23/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 221	be treated." The survithe residents failed?" "By allowing all of this Vice-President of Open happy with the way thall. All we can do is reprior to exit no further (1) Psychosis: any norganic or emotional gross impairment in reindividual incorrectly his or her perceptions incorrect references a in the face of contrary (2) Dementia: a progresion of intelled and impairment of condimpulses. (3) Depression: an a characterized by exagusadness, melancholy emptiness, and hopel inappropriate and out The above definitions Dictionary of Medicine Professions 8th Editions	ted, "How You would want to reyor then asked, "How were The Administrator stated, to happen." The Regional erations stated, "We are not be residents were treated at move forward from here." information was shared. Inajor mental disorder of corigin characterized by a reality testing, in which the revaluates the accuracy of and thoughts and makes about external reality, even a revidence. In a company to the residence of corigin characterized by a reality testing, in which the revaluates the accuracy of and thoughts and makes about external reality, even a residence. In a company to the residence of corigin characterized by a reality testing, in which the revaluates the accuracy of and thoughts and makes about external reality, even are verificated by chronic personality ion, disorientation, stupor, rectual capacity and function, and the company to the residence of the residence of proportion to reality. In a company to the residence of the re	F 2	221		
F 223 SS=E			F2	223		3/17/17

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION G	COMPLETED		
		495258	B. WING		02/2	3/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434	02/2	3/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 223	Continued From pag	ge 50	F 2	23		
	neglect, misappropriand exploitation as dincludes but is not licorporal punishmen any physical or cher treat the resident's see 483.12(a) The facilitia (a)(1) Not use verba abuse, corporal puniseclusion; This REQUIREMEN by: Based on staff interfacility document revalusity document revalusity acomplaint investigensure 2 of 10 resident #1 and #3 of a physical restrain resident's medical see The State Survey Aganonymous complaint alleged a resident hickney are identified in the common As a result of the coconducted by this Seounded that the face	y must- I, mental, sexual, or physical ishment, or involuntary T is not met as evidenced views, clinical record review, view and during the course of ation the facility staff failed to ents in the survey sample, were free from abuse by use in not required to treat the symptoms.		F-223 1 A Res. # 1 & 3 were pexamined to ensure no physical resis being use 1 B Facility Abuse Policy was to include the use of restraints. 2. All residents are at risk for issue. 3 A Inservice provided to curstaff on amended Abuse Policy by members of the Management Stafand B Inservice for the DON or investigation of allegations of abust the Reg. Vice President of Operatana C Facility will provide sufficient to meet the needs of the resis B D Facility implemented a physical restraints	estraint s revised this rrent ff. n se by cions. cient dents. ical reek to	
	medical symptoms f #1 and #3). 1. The facility staff fa	or two residents (Residents ailed to ensure that Resident use by the use of a physical		use. 4 A The above audit will be performed for the street of the street	ormed o ensure	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
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	1		STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434		02/20/2017
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	ULD BE	(X5) COMPLETION DATE
restraint (a gait belt) physical restraint wa and not required to the Resident #1 was resigned belt for approximuntil 10-10:30 am the February 10, 2017. 2. The facility staff for #3 was free from above restraint (a gait belt) movement, that was resident's symptoms The findings include 1. Resident #1 was resident's symptoms The findings include 1. Resident #1 was resident's symptoms The findings include 1. Resident #1 was resident's symptoms The findings include 1. Resident #1 was resident's symptoms The findings include 1. Resident #1 was resident's symptoms The findings include 1. Resident #1 was resident's symptoms The findings include 1. Resident #1 was resident's symptoms The findings include 1. Resident #1 was resident's symptoms The findings include 1. Resident #1 was resident's symptoms The findings include 1. Resident #1 was resident's symptoms The current MDS (Moving with an assessment 1/31/17 coded the respossible 15 on the Boverly impaired day the resident was condisorganized thinking any behaviors. The resident was conditional to the resident	on February 9, 2017. The is used to prevent movement, reat the resident's symptoms. Itrained in a wheelchair with a mately 14 hours from 8:00 pm is following morning of ailed to ensure that Resident use by use of a physical in January 2017, to prevent not required to treat the standard readmitted on 1/4/17 spital stay from 12/28/16 cute urinary retention (1). BPH (benign prostatic zheimer's dementia. Inimum Data Set) a 30 day reference date (ARD) of esident as scoring a 3 out of a stMS (Brief Interview for eating the resident had aily decision making skills. ded as having inattention and g. The resident did not exhibit resident was able to walk a his/her room and in the vith limited assistance of one is used were a walker and dent had a Foley catheter for	F 22	audited by the Administrator to en thorough investigation is complete 4 C DON or designee will review staffing sheets M-F to ensure suff staff is scheduled.	ed. the icient	
	ROVIDER OR SUPPLIER CARE OF SUFFOLK SUMMARY S (EACH DEFICIENT REGULATORY OR REGULATORY OR REGULATORY OR REGULATORY OR RESIDENT	A95258 ROVIDER OR SUPPLIER CARE OF SUFFOLK SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 51 restraint (a gait belt) on February 9, 2017. The physical restraint was used to prevent movement, and not required to treat the resident's symptoms. Resident #1 was restrained in a wheelchair with a gait belt for approximately 14 hours from 8:00 pm until 10-10:30 am the following morning of	ROVIDER OR SUPPLIER CARE OF SUFFOLK SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 51 restraint (a gait belt) on February 9, 2017. The physical restraint was used to prevent movement, and not required to treat the resident's symptoms. Resident #1 was restrained in a wheelchair with a gait belt for approximately 14 hours from 8:00 pm until 10-10:30 am the following morning of February 10, 2017. The facility staff failed to ensure that Resident #3 was free from abuse by use of a physical restraint (a gait belt) in January 2017, to prevent movement, that was not required to treat the resident's symptoms. The findings included: 1. Resident #1 was originally admitted to the facility on 12/23/16 and readmitted on 1/4/17 following a short hospital stay from 12/28/16 through 1/4/17 for acute urinary retention (1). Diagnoses included BPH (benign prostatic hyperplasia), and Alzheimer's dementia. The current MDS (Minimum Data Set) a 30 day with an assessment reference date (ARD) of 1/31/17 coded the resident as scoring a 3 out of a possible 15 on the BIMS (Brief Interview for Mental Status), indicating the resident had severely impaired daily decision making skills. The resident was coded as having inattention and disorganized thinking. The resident did not exhibit any behaviors. The resident was able to walk between locations in his/her room and in the corridor on the unit with limited assistance of one staff. Mobility devices used were a walker and wheelchair. The resident had a Foley catheter for bladder drainage. Under Section J. 1800 Fall history coded the resident as not having any falls	ROVIDER OR SUPPLIER CARE OF SUFFOLK SUMMARY STATEMENT OF DEFICIENCIES (REACH OFFICIENCY MUST BE PRECEDED BY FULL (REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 51 restraint (a gait belt) on February 9, 2017. The physical restraint was used to prevent movement, and not required to treat the resident's symptoms. Resident #1 was restrained in a wheelchair with a gait belt for approximately 14 hours from 8.00 pm until 10-10:30 am the following morning of February 10, 2017. 2. The facility staff failed to ensure that Resident #3 was free from abuse by use of a physical restraint (a gait belt) in January 2017, to prevent movement, that was not required to treat the resident's symptoms. The findings included: 1. Resident #1 was originally admitted to the facility on 12/23/16 and readmitted on 1/4/17 following a short hospital stay from 12/28/16 through 1/4/17 for acute urinary retention (1). Diagnoses included BPH (benign prostatic hyperplasia), and Alzheimer's dementia. The current MDS (Minimum Data Set) a 30 day with an assessment reference date (ARD) of 1/3/1/17 coded the resident as scoring a 3 out of a possible 15 on the BIMS (Brief Interview for Mental Status), indicating the resident had severely impaired daily decision making skills. The resident twas coded as having inattention and disorganized thinking. The resident did not exhibit any behaviors. The resident was able to walk between locations in his/her room and in the corridor on the unit with limited assistance of one staff. Mobility devices used were a walker and wheelchair. The resident as not having nay falls history coded the resident as not having nay falls	A BUILDING 495258 ROWDER OR SUPPLIER CARE OF SUFFOLK SUMMARY STATEMENT OF DEFICIENCES (EACH OBEDISON MONTH PRICE PROCEDED BY FOLL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 51 restraint (a gait belt) on February 9, 2017. The physical restraint was used to prevent movement, and not required to treat the resident's symptoms. Resident #1 was restrained in a wheelchair with a gait belt for approximately 14 hours from 8:00 pm until 10-10:30 am the following morning of February 10, 2017. 2. The facility staff failed to ensure that Resident #3 was free from abuse by use of a physical restraint (as thell) in January 2017, to prevent movement, that was not required to treat the resident's symptoms. The findings included: 1. Resident #1 was originally admitted to the facility on 12/23/16 and readmitted on 1/4/17 following a short hospital stay from 12/28/16 through 1/4/17 for acute urinary retention (1). Diagnoses included BPH (benign prostatic hyperplasia), and Alzheimer's dementia. The current MDS (Minimum Data Set) a 30 day with an assessment reference date (ARD) of 1/3/117 coded the resident as scoring a 3 out of a possible 15 on the BIMS (Brief Interview for Mental Status), indicating the resident had severely impaired daily decision making skills. The resident was able to walk between locations in his/her room and in the corridor on the unit with limited assistance of one staff. Mobility devices used were a walker and wheelchair. The resident had a Foley catheter for bladder drainage. Under Section J. 1800 Fail history coded the resident as not having any falls

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	495258	B. WING		C 02/23/2017	
CARE OF SUFFOLK			STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434	1 02/20/2017	
(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODER (CONTROL OF THE APPRODE)	JLD BE COMPLETION	
Assessment. This or record and the com Centered Plan of Cahad a fall on 1/8/17 The Resident Center 12/24/16 evidenced at risk for falls/impa confusion related to vision related to vision related to glaulcers and debility. 2/9/17. The goal was an injury due to a fall Interventions listed safety did not include restraint. An initial tour of the 2:30 am to 3:00 am tour of the facility all their beds asleep, to A night shift nurse (LPN #3) working on #1's room was located am. She was asked allegations of a resist to a wheelchair. She circumstances for the stated, "He had falled shift), when I arrived onit was buckled I behind the nurses set stayed up all night as periodically would beriad a state of the circumstance of the stayed up all night as periodically would be	was inaccurate as the clinical prehensive Resident are evidenced the resident which was prior to the ARD. Bred Plan of Care initiated the resident was identified as ired safety related to a Alzheimer's dementia, poor ucoma, history of chronic leg Fall on 1/8/17 and fall on as the resident will not sustain all through review. To prevent falls and promote the the use of a physical facility was conducted from an on 2/21/17. During the initial tresidents were observed in the include Resident #1. Licensed Practical Nurse/ at the East unit where Resident the dwas interviewed at 3:00 doing if she was aware of any dent having been restrained the stated, "Yes, (name of the was asked about the ne use of the restraint. She can earlier in the shift (3-11 pm do to work he had a gait belt behind the wheelchair, he was station in the wheelchair, he at the nurses station, the asked if he wanted to go	F 22	23		
	OVIDER OR SUPPLIER SUMMARY S (EACH DEFICIEN REGULATORY OF Continued From par Assessment. This is record and the com Centered Plan of Ca had a fall on 1/8/17 The Resident Center 12/24/16 evidenced at risk for falls/impa confusion related to yision related to gla ulcers and debility. 2/9/17. The goal wa an injury due to a fa Interventions listed safety did not include restraint. An initial tour of the 2:30 am to 3:00 am tour of the facility al their beds asleep, to A night shift nurse (LPN #3) working on #1's room was local am. She was asked allegations of a resi to a wheelchair. She Resident #1)". She circumstances for the stated, "He had falle shift), when I arrived onit was buckled I beck to bedhe wa quietly, did not try to	OVIDER OR SUPPLIER SARE OF SUFFOLK SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 52 Assessment. This was inaccurate as the clinical record and the comprehensive Resident Centered Plan of Care evidenced the resident had a fall on 1/8/17 which was prior to the ARD. The Resident Centered Plan of Care initiated 12/24/16 evidenced the resident was identified as at risk for falls/impaired safety related to confusion related to Alzheimer's dementia, poor vision related to glaucoma, history of chronic leg ulcers and debility. Fall on 1/8/17 and fall on 2/9/17. The goal was the resident will not sustain an injury due to a fall through review. Interventions listed to prevent falls and promote safety did not include the use of a physical	OVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 52 Assessment. This was inaccurate as the clinical record and the comprehensive Resident Centered Plan of Care evidenced the resident had a fall on 1/8/17 which was prior to the ARD. 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She was asked about the circumstances for the use of the restraint. She stated, "He had fallen earlier in the shift (3-11 pm shift), when I arrived to work he had a gait belt onit was buckled behind the wheelchair, he was behind the nurses station in the wheelchair, he was behind the nurses station in the wheelchair, he stayed up all night at the nurses station, periodically would be asked if he wanted to go back to bedhe was alert with confusionhe sat quietly, did not try to fight the restraint." When	OVIDER OR SUPPLIER 2880 PRUDEN BOULEVARD SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 52 Assessment. This was inaccurate as the clinical record and the comprehensive Resident Centered Plan of Care evidenced the resident had a fall on 1/8/17 which was prior to the ARD. 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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495258	B. WING			C 02/23/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434	I	02/23/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 223	stated, "Out of sight had asked the CNA assigned to the reside 5:00 am. LPN #3 was asked in initiated the gait belt she repeated that it I resident by the 3-11 exactly who placed the When asked as a Mashould you have dor "Report it to the DOI LPN#3 stated she with (2/10/17-2/12/17), in the abuse and restration the remove at will, which movement. On 2/21/17 at 3:20 at (DON) was interview Resident #1 being rewinded with a copy report about this aller report noted Resident belt restraining him to the not obtain written with was asked if the Phy Representative were gait belt was used to stated, "No". The Dot (Facility Reportable State Survey Agency).	out of mind". She stated she (Certified Nurse Aide/CNA#3) dent to remove the gait belt not to bed at approximately If she was the one who restraint she stated, "No", had been placed on the shift, she did not know he restraint on the resident. " andated Reporter what he? Her response was N (Director of Nursing)". as suspended for three days serviced and given a copy of	F 2	23		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	l \ /	(X3) DATE SURVEY COMPLETED	
		495258	B. WING			C)2/23/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434	1	12/23/2017
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F 223	incident as abuse as stated the staff failed restraint policy. The aware of the restrain wheeled the residen 10-10:30 am on 2/10 belt around his waist of the wheelchair. The investigation repworking the 3-11 pm East unit on 2/9/17. worked five (5) were RN Supervisor and tinterviewed. The interviewed. The interviewed. The interviewed. The interviewed. The interviewed. The interviewed interviewed interviewed interviewed interviewed. The staff Nurse)- She knew (Fon from 3-11 and mehad been put on him 2/9/17. She kept him her. She said that sh Nurse Aide) (name) the shift. 2. 3-11 pm LPN #2-the nurse (LPN #1) I resident had a fall at there was anything we resident from falling. 4 aides (CNAs-Certi 3. 3-11 pm LPN #1 (#1)- She said that (Lhim and that since slong as (LPN #2) she it. She wanted to kee since there was son 4. 3-11 pm CNA #1 a said the resident slid	at she did not consider this there was "no harm". She do to follow the facility's DON stated she was made at when the Rehab Director to the office between 0/17. The resident had a gait that was buckled in the back doort failed to include all staff and 11 pm-7 am shift on the Off the ten (10) staffed interviewed. The 3-11 pm he day shift CNA were erviews were as follows: t LPN #3 (Licensed Practical Resident #1) had a gait belt eant to remove it. She said it is because of a fall he had on a at the nurses station with the had told the CNA (Certified to take it off before the end of She said Yes she had helped ocate a gait belt after the 8 pm. She did not think wrong with keeping the She stated there were only	F 2	23		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G	` ′	(X3) DATE SURVEY COMPLETED	
		495258	B. WING			C 02/23/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434		02/23/2017
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F 223	She knew it was wro saying anything to the was not agitated or upon to the saying anything to the was not agitated or upon to the saying anything to the was not agitated or upon to the saying anything to the was not agitated or upon to the saying and the saying	belt the nurses put on him. Ing but was uncomfortable the charge nurse. The resident uncomfortable. She did not have any ted to) the night before. It done any care on him when that been resistant. He had ten she came on the shift. In gait belt in place. If pm- Stated she only knew not know about the gait belt. In, the Administrator was ted he had instructed the tigation. Parties involved the ups were done, services were conducted. He is restraint free, clarifying, "As inwe don't use restraints." Isked, "Is the use of a gait belt of a FRI was sent to the State thated, "No, because there is the world to the Board of Health do, "No, I did not report itit	F 2	23		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED	
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F 223	When asked about the restraint she stated, "be considered a restrabusewe need to kee want him up and dow (restraint) policyI do because there was not DON was upset and it gait belt. She stated implemented other intincrease supervision, toileting, and pain". An incident report date pm by LPN #1 noted on both knees on the resident was assisted (wheelchair). No injurting immediately placed a monitoring. The Phys Representative (RR) resident was alert, or confused. The Physician was confused.	edhe did not smell fresh". e use of the gait belt for a That is not policyit would aintnot a form of eep him safethey didn't nthey didn't follow on't consider it abuse o harm". She stated the mmediately removed the the staff could have terventions such as: checking on needs such as ed 2/9/17 entered at 8:05 Resident #1 was observed left side of his bed. The x 2 into his w/c ies noted. The resident was t the nurses station for close ician and the resident was notified of the fall. The ented to person and ontacted via phone on The Physician was asked if to obtain an order to restrain onse was, "No, no one has bout restraintswhoever ore?"When asked if he dent #1 was physically belt in a wheelchair after in 2/9/17, he stated, "They in/her) being restrained is asked, "Would you have y) to inform you after they the teresident was	F	2223			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495258	B. WING			C 02/23/2017
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F 223	2:15 pm. She stated restraint at the nurse restraint on him" Sasked if he wanted to She stated the reside approximately 3:00 a drainage bag, the reresident was placed She stated when she approximately 4:00 a reapplied. She did no stated, "We are always on 2/21/17 at approximately 4:00 are applied. She did no stated, "We are always interviewed in president had a fall dupass at approximate found at his bedside was placed back into placed at the nurses of LPN #2) was at the went to go give more restraint on him I had computer and the fall belt) was tied to the restraint When asked provided care by CN the wheelchair and to she stated, "I didn't recontinued to state the	wed by phone on 2/21/17 at d, "He was already in the estation3-11 put the he stated the resident was o go to bed and stated no. ent was taken to his room at am to empty the Foley straint was removed and the back at the nurses station. et finished rounds at am, the restraint had been obt know by whom. She hays short staffed". Eximately 2:20 pm, LPN#1 erson. She stated the uring the evening medication by 8:00 pm. The resident was on his knees. The resident of the wheelchair and then station. She stated, "(name enurses stationwhen I emeds she had put the end a lot to do with the end a lot to do with the end at lot to do with the e	F 22	23		
	gait belt was a form have just learned that On 2/21/17 at 2:50 p	en asked if a restraint with a of abuse, she stated, "Yes, I hat". In the stated if a restraint with a many stated in the st				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` <i>'</i>	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		495258	B. WING		C 02/23/2017
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F 223	for the use of a gait Resident #1 was, "(Ir resident was extrem and she bought him kept wrapping his Format petals(LPN #3) stated helped her (LPN #3) between we tried to residentswe are all be a gamejust to kepulling out his cather want me to take that "No, keep it on him" the gait belt as a resund not to treat a systated, "I don't belied else to doyour und donewe were under the physician was castated, "No". When a command (the Admix were okay with the command the said anything". When a command he said anything". When a command he said anything was estated, chain of command he said anything the survey do observed in his room in a wheelchair was the resident was obsed. The resident was obsed. The resident was net with nonsensical, saying	to explain the circumstances belt as a restraint for name of LPN #3) is a liarthe ely agitated, he had fallen to the nurses stationhe bley catheter around the foot ated, I wish I had a gait beltI put the gait belt on himin care of the other ways short (staffed)it got to the the pole in from falling and terI asked (LPN #3) do you at gait belt off him, she said when asked if the use of the traint to prevent movement in mptom was abuse, she we it isI don't know what the pressure to get your stuff the critical for a restraint order, she asked if the chain of nistrator, DON, Supervisor) use of the gait belt as a "Yes, because I know the ten asked if it was common "No, it is not".	F2	223	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495258	B. WING _			C 02/23/2017
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F 223	responses. The Physician Order Completed, Disconti through 2/28/17 was physician order(s) for restraint, type of rest duration of the restra policy dated 7/2015. The facility's investige evidenced the restra on Resident #1 for comovement, and not to None of the staff tha restraint stopped the The clinical record erestraint stopped the Representative was benefits of (restraint) Informed Consent for Review of the Nursing and LPN #2 were not investigation, to proto #1 worked on 2/12/12/11, and 2/12/17. The DON failed to the report abuse and fail from harm during the Abuse Policy" revise address chemical and abuse.	r Summary Report for Active, nued date range 1/1/17 reviewed. There were no reviewed. There were no reviewed. There were no reviewed. There were no reviewed in the application of a physical traint, reason for use or the sint per the facility restraint. In the per the facility restraint was deliberately placed convenience, to prevent to treat a medical symptom. It were witnesses to the enabuse or reported it. In the per the facility restraint was deliberately placed convenience, to prevent to treat a medical symptom. It were witnesses to the enabuse or reported it. In the per the facility restraint was deliberately placed convenience, to prevent to treat a medical symptom. It were witnesses to the enabuse or reported it. In the per the facility restraint was deliberately placed on the risk and the device; or a signed or Use of Restraints. In the per the facility restraint was deliberately placed on the risk and the restraint was deliberately placed on the risk and the restraint was deliberately placed on the risk and the restraint was deliberately placed on the risk and the restraint was deliberately placed on the risk and the restraint was deliberately placed on the risk and the restraint was deliberately placed on the risk and the restraint was deliberately placed on the risk and the restraint was deliberately placed on the risk and the restraint was deliberately placed on the risk and the ris	F 2:	23		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495258	B. WING		C 02/23/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434	1 02/23/2017
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F 223	Director of Nursing, the Regional Vice-P the above informatic asked the Administr or physically restrain without injury or har Administrator stated through the process abuse policy it is consurveyor then asked failed?" The Adminiof this to happen." of Operations stated way the residents with do is move forward further information via a result of the surviginia Resident Abrecognition of chemical abuse. The revision (physical or chemical order an in complian	the Administrator, the the Compliance Nurse, and resident of Operations where on was shared. Surveyor #2 ator if a resident is chemically ned to prevent movement m is this abuse. The , "At this time yes, going of this and rewriting the nsidered abuse." The I, "How were the residents strator stated, "By allowing all The Regional Vice-President I, "We are not happy with the ere treated at all. All we can from here." Prior to exit no	F 22	23	
	reviewed: Include R Responsibilities revi revised 7/15. 1). Resident Rights revised 11/16, is dor Policy: It is the facil resident rights, and to residents and the in a language that the	policies and Procedures esident Rights and Facility sed 11/16, and Restraints and Facility Responsibilities cumented in part, as follows: ity's policy to abide by all to communicate these rights ir designated representatives hey can understand. Ind Facility responsibilities are:			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
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F 223	to a dignified existen communication with services inside and of those specified in thi (1) Dignity, Res facility must treat ead dignity and care for eand in an environme maintenance or enhalo of life, recognizing earthe facility must profit the resident. (e) Respect and Dig (1) Restraints: physical or chemical purposes if discipline required to treat the symptoms, consister 2.) "Restraints" is do Policy: Physical and/initiated only after a determines that they resident's medical sy use. Definitions: Physical method or physical of material, or equipmethe resident's body the remove easily which movement or normal Procedure: Physical A) Using the Restraid determine if the device restris a restraint.	this: The resident has a right ce, self-determination, and and access to persons and outside the facility, including is section. pect, and Quality of Life: a ch resident with respect and each resident in a manner into that promotes ancement of his or her quality ach resident's individuality. Sect and promote the rights of the right to be free from any restraints imposed for ad or convenience, and not resident's medical at with 483.12(a)(2). Commented in part, as follows: for chemical restraints will be comprehensive review are necessary to treat the remptoms that warrant their. Restraint-any manual or mechanical device, and attached or adjacent to the the individual cannot restricts freedom of access to one's body. Restraints and Decision Tree (Form 3.40) are restricts the residents.	F 2	23			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495258	B. WING		C 02/23/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434	1 02/25/2017
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F 223	Continued From page	e 62	F 22	23	
	is a restraint. Before the interdisciplinary to 1. Evaluates factonsideration of the consideration of the restraint being consideration of the resident. 6. Analyze all in its device most appropanies and the consideration of the resident. b. When is consideration of the consideration of the restraint of the restraint being consideration of the restraint being consideration of the resident. b. When is consideration of the consideration of the restraint being consideration of the restraint by Resident's responsible type of restraint of the restraint by Resident's responsible type of restraint of the restraint by Resident's responsible type of restraint of the restraint by Resident's responsible type of restraint of the restraint by Resident's responsible type of restraint of the restraint by Resident's responsible type of restraint being consideration of the restraint by the consideration of the restr	proceeding with the device cam: tors leading to the device. at all the resident's needs are ed to restrain is not due to that all alternative measures and found to be sks versus benefits of the dered. Ent and family in decision those regarding risks and formation and decide which priate. En happened/or is happening the need occurring? The cause? Enventions have been tried? The previous interventions The least restrictive device? The nance resident's quality of the party will be educated			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING _	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495258	B. WING		C 02/23/2017
	ROVIDER OR SUPPLIER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 580 PRUDEN BOULEVARD BUFFOLK, VA 23434	OE/2017
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F 223	Definitions: Abuse- Includes act infliction of injury, ur intimidation, or punisharm, pain or menta abuse, sexual abuse abuse including abuse	resident property by anyone. ions such as the willful preasonable confinement, shement with resulting physical anguish. It includes verballe, physical abuse, mental se facilitated or enabled echnology, misappropriation exploitation, involuntary es of unknown source, cal restraints. It is definition of abuse, I must have acted at the individual must have ury.) all or chemical)-may only be and in compliance with delines of Fall Prevention and and Procedure. Identification-Facility's ide: of staff on each shift in one the needs of the re that the staff assigned have dividual residents' care needs. In: A side effect of the bladder dy. It is a common gn prostatic hyperplasia.	F 223		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495258	B. WING _				23/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434	DE	, , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 223	physical restraint to be not required to treat to be not required to treat to the not required to the not requ	se by allowing the use of a be applied in January 2017 the resident's symptoms. If year old admitted to the ith diagnoses to include intia (2), Major Depressive The mum Data Set (MDS) The Brief Status (BIMS) was a 3 out of indicated Resident #3 was impaired and incapable of included in the section C1310 conset Mental Status in the was coded 0 indicating no, included in the section C1310 conset Mental Status in the section C1310 conset Mental S	F 2	223			
	Interventions: *1/18/17 Anti thrust c	ushion to WC (wheelchair)					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		495258	B. WING _			C 02/23/2017	
	ROVIDER OR SUPPLIER	10000		STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434		02/23/2017	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 223	1/18/17. Revision of *11/1/16 Bed sensor mattress, fall mat, or w/c (wheelchair), be imitated: 4/7/16. Reference: (Name of R. Cognition and conting decline R/T (related dementia. Date imitated: 4/7/16. Interventions: *App. Date imitated: 4/7/16. Tocus: Chronic/profunctioning character judgement, decision related to Dementia Revision on: 5/17/16. The patient with respect of the potential to demential to de	shions. Date imitated: on: 2/21/17. or, chair sensor, concave door alarm, drop seat in the ed in lowest position. Date evision on: 2/21/17. desident #3) has Altered nues to have the potential for it to) DX (diagnosis) of itated: 4/7/16. Revision oroach in a calmer manner. 16. ogressive decline in intellectual erized by deficit in memory, or making and thought process a. Dated Imitated: 5/17/16. 16. ond observe for non-verbal ed: 5/17/16. ident. Dated Imitated: en resident makes as. Dated Imitated: 5/17/16. desident #3) continues to have nonstrate physical behaviors. #3) has a hx (history) of being f. Date Imitated: 2/13/17.	F 2	23			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
		495258	B. WING				C 23/2017
	ROVIDER OR SUPPLIER		•	2	TREET ADDRESS, CITY, STATE, ZIP CODE 580 PRUDEN BOULEVARD SUFFOLK, VA 23434		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 223	comfortable, relaxed, imitated: 2/13/17. R *Monitor/document/re of danger to self and 1/24/17. *When the resident be when necessary before Guide away from soccalmly in conversation staff to walk calmly a Date imitated: 2/13/2 On 2/21/17 at 4:00 a conducted with the A asked if restraining a a form of abuse. The we consider it not folluse." On 2/21/17 at 9:15 a conducted with CNA Assistant) who works complaint the Office of Certification had received at the complaint the Office of Certification complaint the Office of Certification had received at the complaint the Office of Certification	to make the resident more etc. as needed. Date evision on: 2/13/17. eport to MD (medical doctor) others. Date imitated: ecomes agitated: intervene ore agitation escalates; arce of distress; Engage n; If response is aggressive, way, and approach later. 17. Revision on: 2/21/17. Im. an interview was dministrator and he was resident with a gait belt was e Administrator stated, "No, lowing procedure for gait belt Im. an interview was #1 (Certified Nursing a the 3-11 shift regarding a	F	2223			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED				
		495258	B. WING _			C 02/23/2017	
	CARE OF SUFFOLK		STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434			02/23/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	(EACH CORRECTIVE CROSS-REFERENCED		DATE	
F 223	The surveyor asked resident was a form "Yes, I should have surveyor then asked had training on abus training on restraints On 2/21/17 at 9:20 a conducted with the Fishift supervisor who the facility and if rest considered abuse. It stated, "We are a no depends on the reside to harm himself, or significant of the provided with CNA Office of Licensure a about a particular result of Resident #3) some because we are alwas surveyor asked when Resident #3 restrained in the facing of Resident #3 restrained in the facing of Resident #3 restrained in the facing facility was a surveyor asked when Resident #3 restrained in the facing facility was an example on people. When she is she is up she can be asked, "Is it abuse to #3 stated, "For me it better than to bust the Cn 2/21/17 at 2:50 pronducted with LPN	CNA #1 if restraining a of abuse. CNA #1 stated, stopped and reported it." The CNA #1 if she had recently e. CNA #1 stated, "We had but not abuse." .m. an interview was RN (Registered Nurse) 3-11 was asked about restraints in raining a resident was The RN 3-11 Supervisor restraint facility and it dent. If the resident is trying lapping their face its not but to for convenience is abuse." .m. a phone interview was #3 regarding a complaint the end Certification had received sident being restrained. CNA #3 was asked if she ther residents being lity. CNA #3 stated, "(Name etimes with a gait belt ays short and she falls." The n was the last time she saw ed. CNA #3 stated. "In the donce in a blue moon. We her while we are changing in bed she is ok, but when a violent lady. The surveyor or restrain a resident?" CNA is not, it is for her safety,	F2	223			

l', '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		495258	B. WING _			02/23/2017	
	ROVIDER OR SUPPLIER CARE OF SUFFOLK		•	STREET ADDRESS, CITY, STATE, ZIF 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434	P CODE		
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F 223	restrained. During asked if she had wi being restrained. L Resident #3) about her wheelchair. Sh gets real combative The Surveyor asked for the resident inst #2 stated, "They coplan for intervention walking her, or toile asked, "Have you e Resident #3)?" LPI restrained her about The surveyor asked you actually restrained the surveyor asked you actually restrain that Resident #3 had order for the restrain physician. LPN #2 doctor or get an ord she was doing all I short staffed." The was abuse to physis #2 stated, "I don't be else to do, you are stuff done and under LPN #2 's employed Written Employee Ordentified and docured.	the interview LPN #2 was tnessed any other residents PN #2 stated, "Yes, (Name of a month ago with a gait belt in the is restrained quite often, she and combative with others." In the is restraining her?" LPN the is a lap-buddy, alarms, the is like a lap-buddy, alarms, the isting her." The surveyor then the ever restrained (Name of N #2 stated, "Yes, I have that a month ago with a gait belt." In the interview is a month ago with a gait belt. In the interview is a month ago with a gait belt. In the interview is a month ago with a gait belt. In the interview is a month ago with a gait belt. In the interview is a month ago with a gait belt in the interview is a month ago with a gait belt in the is a month ago with a gait belt. In the interview is a month ago with a gait belt in the is a month ago with a gait belt. In the interview is a month ago with a gait belt. In the interview is a month ago with a gait belt. In the interview is a month ago with a gait belt. In	F	223			

		STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		G		
		495258	B. WING _		C 02/23/2017	
	CARE OF SUFFOLK			STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434	1 02/25/2017	
	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION	
U II	LPN #2) received the well as Resident right re-educated on proper that are a fall risk. LPN #2 refused to sign Counseling. On 2/21/17 at 3:15 p. the Administrator, the and the Regional Vice where the above inforegarding Resident # #2 and witnessed by DON stated, "We were been restrained and vimmediately." Resident #3's active a Physician Orders for were reviewed. No Fas received or discontestraint for Resident Resident #3's Medicator January and Febrithe review concluded under the care of LPN and 11 nights in Febritals.	Aritten warning. (Name of a facilities restraint policy as a sts. (Name of LPN #2) was are interventions for residents. In a meeting was held with a Director of Nursing (DON) are President of Operations rmation was shared as being restrained by LPN CNA #1 and CNA #3. The re not aware she had also we will start an investigation and discontinued monthly January and February 2017 Physician order was identified at a start an investigation are start an investigation and discontinued monthly January and February 2017 Physician order was identified at a start an investigation are start and a start an investigation are start and discontinued monthly January and February 2017 Physician order was identified at a start an investigation at the start and a start a	F 2:	23		
I I I I I I I I I I I I I I I I I I I	Continued From page Understanding resided Disciplinary action: VLPN #2) received the well as Resident right re-educated on proper that are a fall risk. LPN #2 refused to sig Counseling. On 2/21/17 at 3:15 p. the Administrator, the and the Regional Vice where the above inforegarding Resident # #2 and witnessed by DON stated, "We were been restrained and vimmediately." Resident #3's active a Physician Orders for were reviewed. No Pas received or discontrestraint for Resident Resident #3's Medica for January and Febron The review concluded under the care of LPN and 11 nights in Febron Resident #3's Nurse's were reviewed and defollows: 1/9/17 at 19:30 (7:30)	er MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) er 69 ent rights. Written warning. (Name of er facilities restraint policy as its. (Name of LPN #2) was its. (Name of LPN #3. The resident of Operations its importance of LPN #3. The resident of Name its importance of LPN #3. entitle Administration Record its importance of LPN #3.	PREFIX TAG	(EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OUL	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495258	B. WING		C 02/23/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434	1 02/20/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFICIENCY)	D BE COMPLETION
F 223	needed. 1/9/17 at 20:03 (8:03) 50 mg (milligrams) G hours as needed for R Administration was: On 2/21/17 the facility surveyor a copy of the (FRI) that was faxed G Health Office of Licen regarding Resident # documented in part, a Injuries: No Incident Type: Allega Describe incident, inc taken: Inappropriate If applicable, date not Responsible party, PI Protective Services), Professions): all 2/21. On 2/22/17 the facility surveyor a copy of the (FRIs) that were faxe of Health Professions being physically restra as follows: 1. Injuries: No Incident Type: Allega Describe incident, incident taken: Nurse restrain to a wheelchair.	Pain "My knee's hurt" prn as I p.m. Tramadol HCL Tablet live 50 mg by mouth every 4 Pain PRN (as needed) Effective. I Administrator provided the Pe Facility Reported Incident Ito the Virginia Department of Posure and Certification Is being physically restrained Position of abuse/mistreat Puluding location, and action Puse of restraints. Pain "My knee's hurt" prn as Position Provided to Position Provided Provide	F 22		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		495258	B. WING			C 02/23/2017	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434		02/23/2017		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 223	Employee action init have employment to 2. Injuries: No Incident Type: Alleg Describe incident, ir taken: LPN did not used as a restraint of Name of employee in LPN #4 Employee action init counseling, re-educing as a restraint of Name of employee incident Type: Alleg Describe incident, ir taken: CNA did not used as a restraint of Name of employee in CNA #3 Employee action init counseling, re-educing the counseling, re-educing the counseling incident, ir taken: LPN did not used as a restraint of Name of employee in LPN #1 Employee action init counseling, re-educing incident, ir taken: LPN did not used as a restraint of Name of employee in LPN #1 Employee action initicounseling, re-educing incident Type: Alleg Describe incident, ir taken: LPN did not used as a restraint of Name of employee in LPN #1 Employee action initicounseling, re-educing incident Type: Alleg Describe incident, ir taken: LPN did not used as a restraint of Name of employee in LPN #1 Employee action initicounseling, re-educing incident Type: Alleg Describe incident, ir taken: LPN did not used as a restraint of Name of employee in LPN #1 Employee action initicounseling, re-educing initial counseling, re-educing initial counseling initia	gation of abuse/mistreat actual properties and action report seeing a gait belt being on a resident. Involved and their position: Initiated or taken: Formal atted on abuse policy. Involved and their position: Initiated or taken: Formal atted on abuse policy. Involved and their position: Initiated or taken: Formal atted on abuse policy. Initiated or taken: Formal atted on abuse policy.	F 23	23			

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C			
	495258	B. WING		02/23/2017	
OF SUFFOLK			2580 PRUDEN BOULEVARD	•	
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stigation done of restraint on (Name to 44 employ artments: No or straint on (Name wing: The LPN #4 state dent #3) with a lasked if she art it and she stadidn't want to inclusion: (Name sident being put of the control of the contr	on reported use of a gait belt ame of Resident #3). Ivees from all shifts and the has ever seen any kind of the of Resident #3) except the exc	F 22	3		
	SUMMARY SUMMAR	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) tinued From page 72 stigation done on reported use of a gait belt restraint on (Name of Resident #3). Ke to 44 employees from all shifts and artments: No one has ever seen any kind of straint on (Name of Resident #3) except the	## A SOLDING ## A SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ## A SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ## A SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ## A STATEMENT OF DEFICIENCIES ## A SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ## A SUMMARY STATEMENT OF DEFICIENCIES ## A SUMMARY STATEMENT OF DEFICE ## A SUMMARY STATEMENT OF DEFICIENCIES ## A SUMMARY STATEMENT OF DEFICIENCIES ## A SUMMARY STATEMENT OF DEFICE #	A 95258 R OR SUPPLIER OF SUFFOLK SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) From page 72 stigation done on reported use of a gait belt restraint on (Name of Resident #3) except the wing: tel LPN #4 stated she had seen (Name of dent #3) with a gait belt once a month or two I asked if she attempted to remove it or rit t and she stated that it wasn't her hall and didn't want to interfere. clusion: (Name of LPN #4) had knowledge of sident being restrained but did not witness the aint being put on. ne of LPN #3: Suspended, reported to the Board of Nursing, termination. ne of CNA #1): Formal written counseling, performance monitoring, ne of CNA #3: Formal written counseling, performance monitoring, ne of CNA #3: Formal written counseling, performance monitoring, ne of LPN #4: Formal written counseling, performance monitoring. 1/22/17 at 3:10 p.m. a phone interview was tucted with LPN #4 regarding her statement be Director of Nursing that she had witnessed dent #3 being physically restrained with a gait belt in her wheelchair in loorway of her room. I thought to myself I byt distracted on my own side and forgot	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495258	B. WING			C 02/23/2017	
	ROVIDER OR SUPPLIER			25	TREET ADDRESS, CITY, STATE, ZIP CODE 580 PRUDEN BOULEVARD UFFOLK, VA 23434	021	20,2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 223	to remove the restrair stated, "No, I did not." the time you saw her was abuse?" LPN #4 because she has falle surveyor asked, "Is piresident abuse and a of abuse?" LPN #4 s about it and yes, I'm a Resident #3's Nurse's 14:15(2:15) p.m. by the informing the resident being physically restrated to notify her that an e to prevent resident from the individual of the non-compliance of our policies and it was be of the non-compliance of our policies and it was be of the non-compliance was also notified. (Name of Resident #3 also notified. Resident #3's Nurse's 15:48 (3:48) p.m. by the resident's daughter physically restrained in part, as follows: "Spoke with resident's Contact about the find completed by the facility in the state of the physically restrained in part, as follows:	urveyor asked, "Did you try nt or report it?" LPN #4 " The surveyor asked, "At restrained did you think it it stated, 'Well, yes and no, en so many times." The hysically restraining a re you a mandated reporter tated, "It is abuse no doubt a mandated reporter." So Note dated 2/21/17 at the Director of Nursing t's daughter of her mother ained by a gait belt is as follows: of Resident #3's daughter) mployee applied a gait belt om rising up out of her w/c ed that this was ar operating procedures and sing investigated. Because et the Department of Health	F	223			

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING		(X3) DATE SURVEY COMPLETED C		
		495258	B. WING		02/23/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434	02/20/2011
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION
F 223	that her mother had Informed her that st work at the facility. concerns or question the facility." On 2/23/17 at 2:30 conducted with Res regarding the reside with a gait belt on 1. Physician was aske consulted with on the physically restrained Attending Physician first I heard of her bender we even restrained have expected them a change in her congiven an order for a The facility "Code or documented in part. Legal Responsibilities Fraud and Abuse: A fraud and Abuse: A fraud and abuse isseport it to their supcomfortable reportir supervisor, the emp Chief Compliance Comply with licensur applicable to the open concerns.	ent was abused. Reiterated no physical injuries. aff involved will no longer Informed her if she had ns to please contact me at o.m. a phone interview was ident #3's Attending Physician and being physically restrained 19/17. Resident #3's Attending dif he was called and enight the resident was diwith a gait belt. The stated, "Yesterday was the eing restrained. I didn't think residents anymore. I would not call me if she was having dition, but I would not have restraint." If Conduct" updated 11/21/16 as follows: Any employee who suspects a ue is required to promptly ervisor. If the employee is not ig the issue to their loyee may report it to the officer. Fication: All employees must re and certification laws eration of the facility.	F 22		
		led "Virginia Resident Abuse 2/21/17 is documented in part,			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495258	B. WING _			C 02/23/2017		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 223	mistreatment, exploi misappropriation of misappropriation of misappropriation of misappropriation of misappropriations: Abuse- Includes actinfliction of injury, unintimidation, or punisharm, pain or mental abuse, sexual abuse including abuse including abuse through the use of teof resident property, seclusion and injuried physical and chemical (*Willful, as used in means the individual deliberately, not that intended to inflict injured per MD order aregulations and guid Management Policy Procedure: 3) Prevention and Identity is procedures.	olerate abuse, neglect, tation of residents, and resident property by anyone. ons such as the willful preasonable confinement, shiment with resulting physical anguish. It includes verbal exphysical abuse, mental se facilitated or enabled exhnology, misappropriation exploitation, involuntary as of unknown source, all restraints. This definition of abuse, I must have acted at the individual must have aury.) all or chemical)-may only be and in compliance with telines of Fall Prevention and and Procedure.	F2	223				
	sufficient numbers to residents, and assur	o meet the needs of the re that the staff assigned have dividual residents' care needs.						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) PROVIDER/SUPPLIER/CLIA (X4) PROVIDER/SUPPLIER/CLIA (X5) MULTIPLE CONSTRUCTION (X6) PROVIDER/SUPPLIER/CLIA (X6) PROVIDER/SUPPLIER/SUPPL		(X3) DATE SURVEY COMPLETED			
		495258	B. WING		C 02/23/2017
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(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION
F 223	Continued From pa	ge 76	F 22	3	
		eled "Restraints" last revised ted in part, as follows:			
	initiated only after a determines that the	emical restraints will be comprehensive review y are necessary to treat the symptoms that warrant their			
	physical or mechan equipment attached body that the individ	any manual method or ical device, material, or I or adjacent to the resident's dual cannot remove easily dom of movement or normal ly.			
	Procedure: Physica	al Restraints			
	determine if the dev	e restricts freedom of			
	is a restraint. Befor the interdisciplinary 1. Evaluates fa consideration of the 2. Determine t being met and the r unmet needs. 3. Determines have been attempte unsuccessful.	actors leading to the e device. hat all the resident's needs are need to restrain is not due to that all alternative measures			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		OMPLETED
		495258	B. WING			C 02/23/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434		02/23/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 223	making and educate benefits. 6. Analyze all ir is device most approa. What hat to the resident. b. When is c. What is d. What inte. Why did work? f. What is t. g. Will it er life? C) Physician order is specifies type of residuration of the restration of the re	dered. ent and family in decision those regarding risks and aformation and decide which apriate. Is happened/or is happening the need occurring? the cause? erventions have been tried? In't previous interventions the least restrictive device? Inhance resident's quality of must be obtained that traint, reason for use, and the traint. Insible party will be educated of device and sign the r Use of Restraints (Form and "Resident Rights and ies" last revised 11/16 is as follows: ty's policy to abide by all o communicate these rights r designated representatives	F 2.	23		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G		DATE SURVEY COMPLETED
		495258	B. WING			C
	ROVIDER OR SUPPLIER	199200		STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434	ı	02/23/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 223	those specified in the (1) Dignity, Refacility must treat eadignity and care for and in an environme maintenance or entrof life, recognizing of the facility must prother resident. (e) Respect and Diagnor of the resident. (e) Respect and Diagnor of the resident of the symptoms of discipling required to treat the symptoms, consisted on 2/23/17 at 3:20 was conducted with Director of Nursing, the Regional Vice-Face the above information asked the Administrator or physically restrain without injury or hard Administrator stated through the process abuse policy it is concorned by the process of the proce	outside the facility, including his section. sepect, and Quality of Life: a cach resident with respect and each resident in a manner ent that promotes hancement of his or her quality each resident's individuality. Otect and promote the rights of grity: The right to be free from any all restraints imposed for sed or convenience, and not exceident's medical ent with 483.12(a)(2). p.m. a pre-exit conference in the Administrator, the standard of President of Operations where you was shared. The surveyor eator if a resident is chemically ned to prevent movement ent is this abuse. The did, "At this time yes, going so of this and rewriting the sensidered abuse." The was asked if she would have yo come forward as mandated by saw Resident #3 restrained. Sing stated, "Yes, absolutely. Spait belt is a dignity issue with	F 23	23		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7 50.25			С	
		495258	B. WING _			02/	23/2017
	ROVIDER OR SUPPLIER			25	TREET ADDRESS, CITY, STATE, ZIP CODE 580 PRUDEN BOULEVARD UFFOLK, VA 23434		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 223	redirect her, gotten he document her behaviorstaff see someone recreport it." The Adminit meant to be treated The Administrator state treated." The survithe residents failed?" "By allowing all of this Vice-President of Open happy with the way the all. All we can do is reprior to exit no further (1) Psychosis: any norganic or emotional gross impairment in reindividual incorrectly this or her perceptions incorrect references a in the face of contrary (2) Dementia: a program disorder characterized disintegration, confus deterioration of inteller and impairment of contraction of inteller and impairment of contractions and impulses. (3) Depression: an anacharacterized by exact sadness, melancholy emptiness, and hopel inappropriate and out.	would have expected them to be up and walked her, to or, to notify the doctor, and if strained to take it off and istrator was asked, "What is with dignity and respect" ted, "How You would want to veyor then asked, "How were The Administrator stated, is to happen." The Regional erations stated, "We are not the residents were treated at move forward from here." Information was shared. Inajor mental disorder of origin characterized by a reality testing, in which the revaluates the accuracy of and thoughts and makes about external reality, even a vevidence. It is originally the strain of the properties of the proportion of the proportion of the proportion of the proportion to reality. In the proportion of	F	2223			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 501251	,		С	
		495258	B. WING			02/	23/2017
	CARE OF SUFFOLK			2	TREET ADDRESS, CITY, STATE, ZIP CODE 580 PRUDEN BOULEVARD UFFOLK, VA 23434		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 223	Continued From page	e 80	F:	223			
F 225 SS=D	This is a COMPLAIN INVESTIGATE/REPC ALLEGATIONS/INDIV CFR(s): 483.12(a)(3)(PRT /IDUALS (4)(c)(1)-(4)	F:	225			3/17/17
	483.12(a) The facility (3) Not employ or othewho-	must- erwise engage individuals					
		guilty of abuse, neglect, opriation of property, or urt of law;					
	or her professional lic						
	licensing authorities a actions by a court of I	e nurse aide registry or any knowledge it has of aw against an employee, unfitness for service as a cility staff.					
	exploitation, or mistre (1) Ensure that all alle	egations of abuse, neglect, atment, the facility must: eged violations involving itation or mistreatment, nknown source and					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495258	B. WING		C 02/23/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434	1 02/25/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 225	reported immediately after the allegation is cause the allegation is cause the allegation serious bodily injury, the events that caus abuse and do not rethe administrator of officials (including to adult protective serv for jurisdiction in long accordance with Staprocedures. (2) Have evidence the thoroughly investigation, or mistrinvestigation, or mistrinvestigation is in procedures administrator or his corepresentative and to with State law, including Agency, within 5 wor if the alleged violation corrective action multiples accomplaint investigation in the facility document revalunce accomplaint investigation investigation and the ported immediately facility and other officiality and other off	resident property, are y, but not later than 2 hours a made, if the events that involve abuse or result in or not later than 24 hours if the the allegation do not involve sult in serious bodily injury, to the facility and to other the State Survey Agency and dices where state law provides geterm care facilities) in the law through established at all alleged violations are tied. Interesting the the togress. In of all investigations to the or her designated to other officials in accordance ding to the State Survey king days of the incident, and on is verified appropriate	F 22	F-225 1 A Res. # 1 was physically examined to ensure no restraint was i place and no injury incurred. 1 B FRI was submitted to the DOH/OLC regarding res. # 1. All required agencies, MD, and RP were notified in compliance with regulatory requireme	rired	
	Survey Agency in a failed to thoroughly i					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION IG	((X3) DATE SURVEY COMPLETED	
		495258	B. WING _			02/2	; !3/2017
NAME OF P	ROVIDER OR SUPPLIER		'	STREET ADDRESS, CITY, STATE, ZIP CODE		02/2	.0/2017
TVAINE OF T	TOVIDER OR OUT FEEL						
AUTUMN	CARE OF SUFFOLK			2580 PRUDEN BOULEVARD			
				SUFFOLK, VA 23434			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
F 225	Continued From page	e 82	F 2	25			
	sample, Resident #1. Based on a complain had been physically rewheelchair to prevent medical symptoms. Mabuse and failed to stresident and as Mandimmediately. The faci other residents from a investigation of the physical page 1.	oresidents in the survey at investigation, Resident #1 estrained with a gait belt to a movement and not to treat Multiple staff observed the op the abuse, protect the lated Reporters report lity staff failed to protect abuse during the ongoing hysical restraint. The facility hly investigate an allegation		3 A Review of the Abuse Policy & Procedure with the Ad and DON by the Regional Vice of Operations. 3 B All facility staff were on the amended Abuse Prever Reporting Policy and Procedur 3 C Any allegation of abuse reported and investigated per rand established policy. 3 D Facility implemented a physical restrainment of the properties of the procedure and investigated per rand established policy.	dministrato Presiden in-service ntion & re. se will be regulation ysical er week to	or nt ed	
	of abuse, and failed to	o report to other officials to vey Agency of an allegation		use. 4 A The above audit will be p 5x weekly randomly on all shif restraints are not in use. 4 B The Administrator or design	erformed fts to ensu		
	The State Survey Age anonymous complain alleged a resident had restrained all day and identified in the comp	ency received an t on February 15, 2017 that d been left in a chair overnight. The resident laint was Resident #1.		audit all allegations of abuse to - Reporting was done to all - Thorough investigation wa completed 4 C All audit results will be sh QAPI meetings. 5. 3/17/17	ensure : agencies as		
	facility on 12/23/16 ar following a short hosp through 1/4/17 for act Diagnoses included E hyperplasia-an enlarg Alzheimer's dementia. The current MDS (Mir with an assessment respossible 15 on the Bli Mental Status), indica	need prostate), and nimum Data Set) a 30 day eference date (ARD) of sident as scoring a 3 out of a MS (Brief Interview for					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495258	B. WING		02/23/2017		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434	1 02/20/2011		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPRIDEFICIENCY)	JLD BE COMPLETION		
F 225	drainage. An initial tour of the 2:30 am to 3:00 am tour of the facility al their beds asleep, to A night shift nurse (LPN #3) working or Resident #1's room at 3:00 am. She was any allegations of a restrained to a whee (name of Resident # circumstances for the stated, "He had falle shift), when I arrived onit was buckled I behind the nurses stayed up at the nur be asked if he want alert with confusion fight the restraint". Was not removed, simind". She stated she was not removed at a circumstance of the stated she was sus (2/10/17-2/12/17), in the abuse and restrasked if she was the	facility was conducted from on 2/21/17. During the initial residents were observed in orinclude Resident #1. Licensed Practical Nurse/on the East unit where was located was interviewed as asked if she was aware of resident having been elichair. She stated, "Yes, #1)". She was asked about the ne use of the restraint. She en earlier in the shift (3-11 pm of to work he had a gait belt been earlier in the wheelchair, he reses station, periodically would ed to go back to bedhe was asked why the restraint he stated, "Out of sight out of she had asked the CNA e/CNA#3) assigned to the the gait belt and place the opproximately 5:00 am. cility's investigation LPN#3 opended for three days reserviced and given a copy of aint policy. LPN #3 was e one who initiated the gait	F 225				
	the abuse and restr asked if she was the belt restraint and sta had been placed on She did not know w	aint policy. LPN #3 was					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	, ,	(X3) DATE SURVEY COMPLETED		
		495258	B. WING _			C 02/23/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434	'	02/20/2011	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORI ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 225	Her response was "For of Nursing)". LPN #3 failed to stop report it. The gait belt was but wheelchair; therefore remove it at will, which movement. On 2/21/17 at 3:20 at (DON) arrived at the interviewed about the being restrained with DON's office this sur copy of the facility's it 2/10/17. This report if found with a gait belt The DON was asked Incident) had been so Agency for this incide asked why a FRI had was that she did not abuse, as there was did not include witne with all staff on shift, potential witnesses starts.	e 84 what should you have done? Report it to the DON (Director a abuse, and immediately ckled in the back of the e, the resident could not ch restricted freedom of m, the Director of Nursing facility. The DON was e allegation of Resident #1 a gait belt. While in the veyor was provided with a nvestigation report dated noted Resident #1 "was restraining him to the chair". If a FRI (Facility Reportable ent to the State Survey ent, she stated, "No". When d not been sent her response consider this incident as "no harm". The investigation as statements, interviews interviews with other such as other residents. She to follow the facility's	F 2	· ·			
	aware of the restrain wheeled the resident 10-10:30 am on 2/10 belt around his waist of the wheelchair. T 11-7 nurse was susp	DON stated she was made t when the Rehab. Director to her office between 1/17. The resident had a gait that was buckled in the back he investigation noted the ended for three days. The urses (LPN#1 and #2) spended during the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495258	B. WING				23/2017	
	ROVIDER OR SUPPLIER				ESS, CITY, STATE, ZIP CODE N BOULEVARD /A 23434	1 021	23/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	,	PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD E OSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 225	Continued From pag	e 85	F 2	225				
	working the 3-11 pm	oort failed to include all staff and 11 pm-7 am shift on the Of the ten (10) staffed interviewed.						
		cognize that a physical vent movement and not to to tom was abuse.						
	allegation of abuse, to the State Survey Arequired by State law	oroughly investigate an report the allegation of abuse Agency and other officials as v, and failed to protect other e during an investigation of						
	interviewed about the Resident #1. He state DON to do the invest parties involved, writere-education and instacility was a restraint clarify he stated, "As don't use restraints". used as a restraint who, we considered it gait belt use". When sent to the State Sur Because there was rasked if the staff involved board of Health Profinot report them as it failure to follow the resident in the staff involved the s	ervices." He stated the at free facility, when asked to in we don't use them, we When asked if the gait belt was abuse, he stated, "Abuse, not following procedure for asked why a FRI was not vey Agency, he responded, "no injury involved". When blved were reported to the essions he stated that he did was a "procedural issue" (a estraint policy).						
	allegation of abuse v	led to ensure a FRI of an vas reported to the State other officials as required by						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495258	B. WING _			C 02/23/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	ZIP CODE	02/2	.5/2017
ALITURANI	CARE OF SUFFOLK			2580 PRUDEN BOULEVARD			
AUTUMN	CARE OF SUFFOLK			SUFFOLK, VA 23434			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CORRECTIVE CROSS-REFERENCED		I .	(X5) COMPLETION DATE
F 225	Continued From page	e 86	F 2	225			
F 225	State law to include a agencies and registric to recognize that a physical prevent movement are symptom was abuse. On 2/21/17 at 9:15 are assigned to care for Finterviewed. She star agitated easilyif the certain tone he gets rewhen I got here, after and up and down from bedhe was having on nurse (LPN#1) didn't him up out of his room out of his roomthey the nurses stationhe his roomat one point behind the nurses stationhe with the nurses stationhe with the stated, "No, beforewith (name owhen she stated, "it ver months". When asket Resident #1 she stated the extra paperwork	inpropriate licensing des. The Administrator failed des. The GNA (CNA#1) desident #1 on 2/9/17 was ded, "He (Resident #1) gets des. The GRESIDENT was fine deally agitatedhe was fine d	F 2	225			
	restraining a resident abuse, she stated, "Y and then report it". V	with a gait belt is a form of iesyou should stop it first, it hen asked why she did not stated, "I was scared of					
	CNA#1 failed to stop report it.	abuse and immediately					
	On 2/21/17 at 2:15 pr	m, the 11-7 CNA (CNA #3)					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495258	B. WING _			C
	ROVIDER OR SUPPLIER	433230		STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434	ı	02/23/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 225	interviewed by phon placed the restraint "He was already in the stated the resident wapproximately 3:00 adrainage bag, the regresident was placed the wheelchair. She rounds at approximatestraint had been rewhom. She stated, "CNA#3 failed to stop report it. On 2/21/17 at approwas interviewed in president had a fall dipass at approximate found at his bedside was placed back interplaced at the nurses of LPN #2) was at the went to go give more restraint on himI h computer and the fabelt) was tied to the restraintWhen ask provided care by CN the wheelchair and I she stated, "I didn't continued to state the oncoming nurse (LP with a belt on". Whe gait belt was a form have just learned the	Resident #1 on 2/9/17 was e. She was asked who had on the resident and stated, he restraint at the nurses e restraint on him" She was taken to his room at am to empty the Foley straint was removed and the back at the nurses station in e stated when she finished ately 4:00 am, she noticed the eapplied. She did not know by We are always short staffed". In abuse and immediately eximately 2:20 pm, LPN #1 erson. She stated the auring the evening medication and the station of the wheelchair and then a station. She stated, "(name are nurses stationwhen I are meds she had put the and a lot to do with the allI didn't realize it (the gait chairit didn't hit me it was a ared if the resident was IA #1 after he was placed in perfore the next shift came in	F2	225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		495258	B. WING _			C 02/23/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434		02/23/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 225	Continued From pag	e 88	F 2	25		
	reported it to the Sup immediately". When aware of the residen belt she stated, " I th When asked who pla Resident #1 she state (LPN #2)". LPN #1 failed to recoprevent movement for treat a medical systop abuse and faile	corrected that action and pervisor or DON asked if the Supervisor was to being restrained with a gait ink she probably did know." aced the gait belt restraint on ed, "I assume it was her assume it was her appropriate a physical restraint to per staff convenience, and not mptom as abuse, failed to did to report it immediately.				
		during the investigation to arm and allowed to work on				
	in person in the presimmediate response for the use of a gait I Resident #1 was, "(resident was extrem and she bought him kept wrapping his Fopetals(LPN #3) stahelped her (LPN #3) between we tried to residentswe are all be a gamejust to k pulling out his cathel want me to take that "No, keep it on him". the gait belt as a resand not to treat a systated, " I don't belie	ame of LPN #3) is a liarthe ely agitated, he had fallen to the nurses stationhe eley catheter around the foot ted, I wish I had a gait beltI put the gait belt on himin				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		495258	B. WING			C 02/23/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434	<u>'</u>	02/23/2017	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 225	the physician was castated, "No". When a command (the Admi were okay with the urestraint she stated, chain of command he said anything". Whe practice, she stated, LPN #2 failed to recrestraint to prevent reconvenience and nowas abuse. Review of the Nursing was not suspended protect other resider work on 2/10, 2/11, and Con 2/23/17 at 1:30 peace was the designated facility. She repeated could not answer. Signefer the Administratives". The Administratives "Yes". The Administratives it's me". The Operations stated it Administrator. The facility's investig for Resident #1 failed 1. Identify the staff in initial reporting. 2. Protect residents investigation by failurinvolved, to include the staff in	erstaffed". When asked if alled for a restraint order, she asked if the chain of nistrator, DON, Supervisor) use of the gait belt as a "Yes, because I know the as seen itand they haven't en asked if it was common "No, it is not". Dognize the use of a physical movement, for staff to treat a medical symptom and Daily Sheets noted LPN #2 during the investigation to the form harm and allowed to and 2/12/17. Dom, the DON was asked who habuse Coordinator for the add the question twice and the was asked if she would enter the asked, and stated for the Administrator stated, "I Regional Vice President of its usually the role of the pation of the physical restraint	F2	25			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495258	B. WING		C 02/23/2017	
	NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF SUFFOLK			STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434	02/23/2017	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 225	incident to the State agencies as required. Prevention-deploy sufficient numbers to residents. The facility's abuse Abuse Policy" revise and define the use of restraints as abuse, Policy: This facility with mistreatment, explois misappropriation of Definitions: Abuse- Includes act infliction of injury, ur intimidation, or punisharm, pain or mental abuse, sexual abuse abuse including abuthrough the use of te	d violation and substantiated Survey Agency and all other	F 22	,		
	seclusion and injurie (*Willful, as used in means the individual deliberately, not that intended to inflict inj Procedure: 3) Prevention and lo procedures will inclu- f. The deployment of sufficient numbers to residents, and assur knowledge of the ind 6). Initial Reports a. Timing-All allegat reported immediatel	es of unknown source. this definition of abuse, I must have acted t the individual must have ury.) lentification-Facility's				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495258	B. WING			23/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434	1 021	20,2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 225	serious bodily injury, DOH (Department of later than 2 hours after 7). Investigation Proteinvestigation the incidente following actions: i. Interview the residente witnesses. Witnesses who witnessed or head close contact with the incidentand employed the accused employed iii. Obtain written state possible, the accused 9). Final report will be State agency, after the but no later than five alleged occurrence. 10). In the case of state facility will follow Facility will follow Facility will follow facility will reposit investigation to the allegand registries in accounter for the above findings we meeting with the Admit of the facility will the Admit of the facility with t	event that caused the nallegation of Abuse or it should be reported to the Health) immediately, but not er the allegation is made. Occol. The person dent should generally take ent, the accused, and all is generally include anyone and the incident; came in experience who worked closely with exelving the end of the vees who worked closely with exelving the investigation is completed, and each witness. It is submitted to applicable the investigation is completed, (5) working days from the estalts of the investigation. Our the results of the investigation out the results of the propriate licensing agencies or dance with the law.	F 23	25		
F 226 SS=L		IT ABUSE/NEGLECT, ETC	F 22	26		3/17/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495258	B. WING		C 02/23/2017
	NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF SUFFOLK			STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434	1 02.20.20.1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLÉTION
F 226	(c)(1) Activities that cexploitation, and missiproperty as set forth a cexploitation, resident property.	levelop and implement rocedures that: ent abuse, neglect, and ents and misappropriation of and procedures to allegations, and a required at paragraph end exploitation. In addition to use, neglect, and exploitation 3.12, facilities must also eir staff that at a minimum enstitute abuse, neglect, appropriation of resident	F 22	F-226 1 A The facility s Abuse Police was revised to include both physical and chemical restrain 1 B All current facility staff were in-serviced on the revised Abuse Prevention Policy and the fact they are	ts.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495258	B. WING_	B. WING			C 02/23/2017	
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP	CODE	02/	23/2017	
				2580 PRUDEN BOULEVARD				
AUTUMN	CARE OF SUFFOLK			SUFFOLK, VA 23434				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BI		(X5) COMPLETION DATE	
F 226	Continued From page	e 93	F 2	226				
F 220	The facility's abuse p January, 2017, failed chemical or physical result, the facility statissues related to abuabuse, thoroughly investedents from harmore report all alleged viol. Based on the complain a sample of 10 reserstrained with a gait prevent movement as symptoms. Multiples failed to stop the abuas Mandated Report facility Administration. Administrator, the Director facility Administration and the residents from abuse investigation of the p staff failed to provide minimum educated sconstituted abuse. During the course of another resident was physically restrained Immediate Jeopardy 10:00 am., under Abuard Procedures-Freedom Exploitation. The findings included	to define the use of restraints as abuse. As a ff failed to train employees on se, prevent abuse, identify vestigate abuse, protect during an investigation, and ations. Anint investigation Resident #1 idents, had been physically belt to a wheelchair to and not to treat medical staff observed the abuse and se, protect the resident and ers report immediately. The ateam to include the rector of Nursing and the atticensed Practical Nurses in the staff ailed to protect other is during the ongoing thysical restraint. The facility training to their staff that at taff on activities that the complaint investigation is identified as having been with a gait belt, Resident #3. was called on 2/21/17 at use Prohibition Policies and in from Abuse, Neglect and		mandated reporter of abuse 2. All residents are at risk 3 A Current staff in-servi revised Abuse Policy and Reporter. 3 B New employees will on the new Abuse Policy in Mandated Reporting by the designee. 3 C Abuse Prevention infradded to employee refere can be attached to their number of the days and their role as a reporter x 60 days and the days. 4 B All audit results will be QAPI meetings. 5. 3/17/17	for this issue ced on the Mandated be in-serviced including the ADON or to has been ince card which ame badge. It is with the configure of current to understand mandated en randomly and the configure of the con	d		
	The State Survey Ag	ency received an						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		495258	B. WING		C 02/23/2017		
	ROVIDER OR SUPPLIER CARE OF SUFFOLK		2	STREET ADDRESS, CITY, STATE, ZIP CODE 1580 PRUDEN BOULEVARD BUFFOLK, VA 23434	1 02/25/2017		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION		
F 226	anonymous compla alleged a resident hrestrained all day aridentified in the com 1. Resident #1 was facility on 12/23/16 following a short ho through 1/4/17 for a Diagnoses included hyperplasia-an enla Alzheimer's dementified in the current MDS (Nowith an assessmentified in the current MDS (Nowith	int on February 15, 2017, that had been left in a chair and overnight. The resident applaint was Resident #1. originally admitted to the and readmitted on 1/4/17 spital stay from 12/28/16 acute urinary retention (1). I BPH (benign prostatic arged prostate), and	F 226				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	(X3) DATE SURVEY COMPLETED			
		495258	B. WING		C 02/23/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434	02/23/2017	
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION	
F 226	periodically would back to bedhe wad quietly, did not try the asked why the rest stated, "Out of sights she had asked the Aide/CNA#3) assignthe gait belt and plate approximately 5:00 LPN #3 was asked initiated the gait between the repeated that it resident by the 3-1 placed the restraint as a Mandated Regione? Her respons (Director of Nursing suspended for three inserviced and give restraint policy. LPN #3 failed to store in the plate in t	at the nurses station, be asked if he wanted to go as alert with confusionhe sat to fight the restraint". When raint was not removed, she t, out of mind". She stated CNA (Certified Nurse ned to the resident to remove ace the resident to bed at	F 220			

_ ` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495258	B. WING_			C 2/23/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434		2/23/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 226	and the Resident Re the facility that a gai Resident #1, she sta asked if a FRI (Facil been sent to the Sta incident, she stated, FRI had not been sed did not consider this was "no harm". She follow the facility's restated she was mad the Rehab Director office between 10-1 resident had a gait to buckled in the back investigation noted is uspended for three licensed nurses (LP not suspended during the investigation reworking the 3-11 pm East unit on 2/9/17, worked five (5) were treat a medical symmathic treat a medical symmathic treat a medical symmathic treat a facility of the State Survey required by State lar residents from harmabuse.	tain written witness N was asked if the Physician epresentative were notified by the belt was used to restrain ated, "No". The DON was ity Reportable Incident) had ate Survey Agency for this "No". When asked why a ent her response was that she incident as abuse, as there is stated the staff failed to estraint policy. The DON are aware of the restraint when wheeled the resident to her 0:30 am on 2/10/17. The belt around his waist that was of the wheelchair. The che 11-7 nurse was a days. The other two N#1 and #2) involved were not the investigation. Sport failed to include all staff and 11 pm-7 am shift on the Of the ten (10) staffed a interviewed. Secognize that a physical event movement and not to	F2	226		

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION ND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED	
495258	B. WING		C 02/23/2017
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF SUFFOLK	2	TREET ADDRESS, CITY, STATE, ZIP CODE 580 PRUDEN BOULEVARD SUFFOLK, VA 23434	02/23/2017
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 226 Continued From page 97 interviewed about the physical restraint use for Resident #1. He stated, "I asked (DON name) the DON to do the investigation, we disciplined parties involved, write-ups were done, re-education and inservices." He stated the facility was a restraint free facility, when asked to clarify he stated, "As in we don't use them, we don't use restraints". When asked if the gait belt used as a restraint was abuse, he stated, "Abuse, no, we considered it not following procedure for gait belt use". When asked why a FRI was not sent to the State Survey Agency, he responded, "Because there was no injury involved". When asked if the staff involved were reported to the Board of Health Professions he stated that he did not report them as it was a "procedural issue" (a failure to follow the restraint policy). The Administrator failed to recognize that a physical restraint used to prevent movement and not to treat a medical symptom was abuse. The Administrator failed to ensure a FRI of an allegation of abuse was reported to the State Survey Agency and other officials as required by State law to include appropriate licensing agencies and registries. On 2/21/17 at 9:15 am, the 3-11 CNA (CNA#1) assigned to care for Resident #1 on 2/9/17 was interviewed. She stated, "He (Resident #1) gets agitated easilyif the nurses talk to him in a certain tone he gets really agitatedhe was fine when I got here, after dinner he was up and down and up and down from the wheelchair to the bedhe was having one of those nightsthe nurse (LPN#1) didn't want him to fall, they bought	F 226		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION IG	· /	(X3) DATE SURVEY COMPLETED	
		495258	B. WING _			C 02/23/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434	<u> </u>	02/20/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 226	the nurses stationhe his roomat one poin behind the nurses stat (LPN#3) got the gait it witnessed LPN#3 app #1 she stated, "No, be beforewith (name or when she stated, "it w months". When aske Resident #1 she state the extra paperwork thereI didn't know w restraining a resident abuse, she stated, "Y and then report it". W report the abuse she (name of LPN #1). CNA#1 failed to stop report it. On 2/21/17 at 2:15 pr assigned to care for F interviewed by phone placed the restraint or "He was already in the station3-11 put the stated the resident was approximately 3:00 ard drainage bag, the res resident was placed be the wheelchair. She straint had been reawhom. She stated, "V	e kept trying to go back to at he got up then he was tionthey got tired of him pelt". When asked if she bly the gait belt to Resident at she has done this f Resident #3). When asked as in the last couple of d why they had restrained ed, "They don't want to do they told me to leave him what to do". When asked if with a gait belt is a form of esyou should stop it first, when asked why she did not stated, "I was scared of abuse and immediately an, the 11-7 CNA (CNA #3) Resident #1 on 2/9/17 was She was asked who had in the resident and stated, e restraint at the nurses restraint on him" She as taken to his room at	F 2	26		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		405050					
		495258	B. WING _			02/	23/2017
	ROVIDER OR SUPPLIER CARE OF SUFFOLK			STREET ADDRESS 2580 PRUDEN BO SUFFOLK, VA			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG	(EAC	ROVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD B S-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 226	was interviewed in resident had a fall of pass at approximate found at his bedside was placed back in placed at the nurse of LPN #2) was at the went to go give more traint on him It computer and the fabelt) was tied to the restraint When as provided care by Counter the wheelchair and she stated, "I didn't continued to state to oncoming nurse (LI with a belt on". When gait belt was a form have just learned the who was responsibe "I am I should have reported it to the Suimmediately". When aware of the reside belt she stated, "I the wheelchair and the stated, "I the whole was a stated, "I the whole was greated belt she stated, "I the when asked who president #1 she stated." LPN #1 failed to recover the prevent movement was abuse, failed to report it immediatel. Review of the Nurs was not suspended.	person. She stated the during the evening medication ely 8:00 pm. The resident was e on his knees. The resident to the wheelchair and then is station. She stated, "(name he nurses stationwhen I are meds she had put the had a lot to do with the had a lot to do with the eallI didn't realize it (the gait e chairit didn't hit me it was a ked if the resident was NA #1 after he was placed in before the next shift came in recall she did". She hat LPN #2 reported to the PN #1) "We have him up here hen asked if a restraint with a nof abuse, she stated, "Yes, I hat". The nurse was asked le for the resident she stated, he corrected that action and supervisor or DON in asked if the Supervisor was not being restrained with a gait think she probably did know." laced the gait belt restraint on atted, "I assume it was her cognize a physical restraint to and not to treat a symptom of stop abuse and failed to	F2	226			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495258	B. WING		05	C 2/23/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 226	2/12/17. On 2/21/17 at 2:50 pin person in the presimmediate response circumstances for the restraint for Residentis a liarthe residential fallen and she bestationhe kept wrater around the foot petal had a gait beltI hele belt on himin between the residentswe got to be a gamejute and pulling out his cayou want me to take said "No, keep it on of the gait belt as a rand not to treat a synstated, "I don't belie else to doyour und donewe were under the physician was castated, "No". When a command (the Admin were okay with the urestraint she stated, chain of command he said anything". Whe practice, she stated, LPN #2 failed to recorrestraint to prevent in convenience and not was abuse.	m, LPN #2 was interviewed ence of Surveyor #2. Her to explain the e use of a gait belt as a t #1 was, "(name of LPN#3) t was extremely agitated, he ought him to the nurses oping his Foley catheter s(LPN #3) stated, I wish I ped her (LPN #3) put the gait een we tried to care of the are always short (staffed)it st to keep him from falling atheterI asked (LPN #3) do that gait belt off him, she nim". When asked if the use estraint to prevent movement mptom was abuse, she we it isI don't know what er pressure to get your stuff erstaffed". When asked if illed for a restraint order, she asked if the chain of inistrator, DON, Supervisor) se of the gait belt as a "Yes, because I know the as seen itand they haven't in asked if it was common "No, it is not".	F 22	26		

	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
B. WING		C 02/23/2017	
2	2580 PRUDEN BOULEVARD	02/20/2017	
ID PREFIX TAG			
F 226			
	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434 ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B TAG CROSS-REFERENCED TO THE APPROPRIA	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		E SURVEY IPLETED
		495258	B. WING		02	C 2/23/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434	, <u>v</u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 226	3. Report the alleged incident to the State agencies as required 4. Prevention-deploy	during the investigation. I violation and substantiated Survey Agency and all other	F 22	26		
	had been affected by of using a gait belt removement, staff con medical symptom, R Resident #3 was a 8 facility on 11/23/14 w Psychosis (1), Deme	ound that another resident the same deficient practice estraint for preventing evenience and not to treat a				
	assessment was a C Reference Date (AR Interview for Mental a possible 15 which	imum Data Set (MDS) Quarterly with an Assessment D) of 1/16/17. The Brief Status (BIMS) was a 3 out of indicated Resident #3 was impaired and incapable of g.				
	was interviewed. Du asked if she had witr restrained. CNA #1 s couple of months (N. gait belt. When I han halls. She (Residen	m, the 3-11 CNA (CNA#1) ring the interview she was nessed any other resident's stated, " Yes, in the past ame of Resident #3) with a we a break I walk around the t #3) was sitting in the air by the nurse's station with				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		405050	D WING				С
		495258	B. WING			02/	23/2017
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ΔΙΙΤΙΙΜΝ	CARE OF SUFFOLK			2	580 PRUDEN BOULEVARD		
AUTOWIN	CARL OF SUFFOLK			S	SUFFOLK, VA 23434		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX	,	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD B		COMPLETION DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	41F	DAIL
			+				
F 226	Continued From page	. 102		226			
1 220			F.	226			
		, she is another one that is					
		comes combative easily."					
		"Who was the nurse taking					
		nat night?" CNA #1 stated,					
	(Name of LPN #2) (L	icensed Practical Nurse).					
	CNA #1 failed to stop	abuse and report it.					
	On 2/21/17 at 2:50 p.	m an interview was					
		#2. During the interview					
		she had witnessed any					
		restrained. LPN #2 stated,					
	_	ent #3) about a month ago					
	with a gait belt in her	,					
	_	, she gets real combative					
	-	thers." The Surveyor asked,					
		e been for the resident					
		her?" LPN #2 stated, "They					
	could have looked at						
		p-buddy, alarms, walking					
	her, or toileting her."	The surveyor then asked,					
	"Have you ever restra	nined (Name of Resident					
	#3)?" LPN #2 stated,	"Yes, I have restrained her					
	about a month ago wi	ith a gait belt." The surveyor					
	asked, "Do you reme	mber what day you actually					
	restrained the resider	nt?" LPN #2 stated, "It was					
	-	n or 24th. I think it was					
		use there was not enough					
	staff to keep my other						
		#2 if Resident #3's physician					
		ner on January 9th that					
		restrained and if an order				ſ	
		een obtained from the					
		ated, "No, I did not call the				ſ	
		r. I can't remember what				ĺ	
		member is that we were				ĺ	
		urveyor asked LPN #2 if it				ĺ	
		Illy restrain a resident. LPN					
	#2 stated, "I don't beli	ieve it is. I didn't know what					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G	` '	ATE SURVEY DMPLETED
		495258	B. WING			C 02/22/2047
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434		02/23/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 226	stuff done and under LPN#2 restrained Re convenience due to The Nursing Daily Si the following staffing East Unit: 3 pm-11 p East Unit: 3 pm-11 p East Unit: 11 pm-7 a West Unit: 11 pm-7 a West Unit: 11 pm-7 a On 2/23/17 at 1:30 p was the designated of facility. She was not Administrator was as Administrator was as Administrator was not The Regional Vice P answered and stated Administrator. The facility's abuse p Abuse Policy" revise and define the use or restraints as abuse, Policy: This facility w mistreatment, exploi misappropriation of r Facility staff must im allegations to the Ad Coordinator. The Ad Coordinator will immi investigation and not state agencies in acc in this policy. 3) Prevention and Id	esident #3 for staff staffing. Desident nurse, 2 CNAs staff staff who as asked who asked who asked who asked who asked who asked the same question. The staff staff staff staff staff staff who asked who asked who asked the same question. The staff s	F 22	26		
	procedures will inclu f. The deployment of	de: f staff on each shift in				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	COMPLETED
		495258	B. WING		C 02/23/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434	02/23/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 226	residents, and assuknowledge of the inception of injury, unintimidation, or punitimidation, or punitimidation, or punitimidation, in intimidation, inti	o meet the needs of the re that the staff assigned have dividual residents' care needs. ions of Abusemust be y* to the Administrator, (DON) and to the applicable event that caused the an allegation of Abuse or, it should be reported to the of Health) immediately, but not fiter the allegation is made. In the accused, and all es generally include anyone eard the incident; came in the resident the day of the oyees who worked closely with	F 22	6	

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED				
		495258	B. WING				23/2017
	ROVIDER OR SUPPLIER			25	TREET ADDRESS, CITY, STATE, ZIP CODE 580 PRUDEN BOULEVARD UFFOLK, VA 23434		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 226	abuse including abus through the use of ted of resident property, a seclusion and injuries (*Willful, as used in the means the individual deliberately, not that intended to inflict injuring 11). Reporting: *Notify next of kin * Notify resident's phyreceives a complaint Procedure: The plan for removal accepted on 2/21/17 included the following 1. How corrective act those residents found the deficient practice. 1a. Both residents (# an Registered Nurse 1b. Observe to ensurplace. 1c. FRI will be compled DOH (Department of Licensure and Certific 2. How will the facility having the potential to deficient practice. 2 a. All residents have affected. 3. Address what mean systemic changes may deficient practice will 3a. Every current residents in the second process of the second proc	physical abuse, mental e facilitated or enabled chnology, misappropriation exploitation, involuntary of unknown source. his definition of abuse, must have acted the individual must have ry.) Visician when the facility of alleged abuse of Immediate Jeopardy was at 3:45 pm. The plan at steps: ion will be accomplished for a to have been affected by 1 and #3) were assessed by for injury. 1 and #3) were assessed by for injury. 2 e no physical restraint in a ted and submitted to the Health)/OLC (Office of cation/State Survey Agency). 3 identify other residents of be affected by the same are the potential to be sures will be put in place or ade to ensure that the	F	2226			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		TE SURVEY MPLETED
		495258	B. WING _		0.	C 2/23/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434	<u> </u>	2/23/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 226	Procedure to include compliance with all r 3c. All current staff e educated/inserviced use of restraints, rep Supervisor/DON/Adr hotline. 3d. Administrator and educated/inserviced allegation/suspected other agencies as red. How the facility playerformance to make sustained. 4a. Audit will be commourrent residents and restraints in place. A randomly on all 3 ships DON or managent consist of visual inspensure no restraint in 4b. Any occurrence will be reported by the DOH/OLC and other 5. Staff education/ins 3 shifts 2/21/17 and needed) or staff who work by 2/23/17 will education provided. The facility revised it Policy & Procedure to The revision included chemical)- may only compliance with region revention and Manager in the staff with the staff provided and the staff provided in the revision included the policy of the staff provided in the revision included the policy with region and Manager in the staff provided in the staff provided in the revision included the policy of the revision included the policy of the provided in the revision included the policy of the provided in the policy of the p	restraints as abuse if not in egulatory requirements. mployees will be on Abuse Prevention P&P, orting of events to ministrator, or compliance d DON will be to report any abuse to DOH/OLC and quired per regulation. ans to monitor its esure that solutions are pleted 5x week, to inspect all d ensure no physical udits will be conducted fts. Audit will be completed nent designee. Audit will ections of each resident to a place. Of alleged/suspected abuse the Administrator /DON to required agencies. Service will be provided on all 2/22/17. Part time, PRN (as have not been scheduled to be contacted by phone and the sexisting Abuse Prevention of include restraints as abuse. It is existing Abuse Prevention of include restraints as abuse. It is existing the period of the used per MD order and in ulations and guidelines of Fall	F2	26		

3/2017
J/ E 0 1 1
(X5) COMPLETION DATE
/17/17

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	COMPLETED			
		495258	B. WING _		C 02/23/2017		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434	·		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION		
F 353	limited to nurse aides (a)(2) Except when we this section, the facil nurse to serve as a conduty. (a)(3) The facility must nurses have the spessets necessary to call identified through residentified through resident care plans an eeds. This REQUIREMENT by: Based on a complair reviews, and staff interior failed to have sufficient nurse aides to provide resident needs. The findings included The facility staff faile including nurse aides respond to residents. Two residents (Residing were found with gait wheelchairs. For residents review of the facility Administrator indicated As the Administrator.	vaived under paragraph (e) of the must designate a licensed charge nurse on each tour of st ensure that licensed cific competencies and skill are for residents' needs, as sident assessments, and of care. Includes but is not limited to g, planning and implementing and responding to resident's It is not met as evidenced ent investigation, record erviews, the facility staff ent nursing staff including le care and respond to d: d to have sufficient staff is to provide care and needs. It and Resident #3) belts restraining them to dent specific information	F 3	F-353 1. On 2/23/17 the Administ received authority to utilize Nurse of Agency if needed to provide adequatily staffing. 2. All residents are at risk for the issue. 3 A DON/ADON will create a schedule for nursing department to facilitate sufficient staffing. 3 B DON will determine nur vacant positions and then advertise recruit, hire for those positions. 3 C DON or designee will rework schedule daily for adequate so numbers and will attempt to cove vacancies (example: call off for sic with available staff or agency. 3 D DON has designated a conurse who is to be called if addition staffing is needed.	Staffing pate his a master of e, eview staffing er any kness) on call		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G	(X	(3) DATE SURVEY COMPLETED	
		495258	B. WING			C 02/23/2017
	ROVIDER OR SUPPLIER CARE OF SUFFOLK			STREET ADDRESS, CITY, STATE, ZIP COD 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434	I	02/23/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 353	accountability necess assigned duties. You out the operational contestablished by the conte	ary for carrying out your are responsible for carrying ore responsibilities mpany and facility. You are versight of the resident care by the facility. S- Core Competencies/Skill ve knowledge of and ets, including revenue and ding of Hours of Labor and 'S (PER PATIENT DAY)." For of Nursing (DON) Job It: "As the Director of Nursing to organize, develop and rations of the Nursing in accordance with current all standards, guidelines and find the facility. The standards of the direct of th	F 38	4 A DON or designee of nursing staffing to Administrat 4 B QAPI Committee of reports from the DON if staffing encountered. An action plan developed as needed. 5. 3/17/17	or daily. vill receive ng issues ar	re

PRINTED: 03/21/2018 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495258	B. WING _			C / 23/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434	, 02	720/2011	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 353	Continued From page	e 111	F3	353			
	7-3 3-11 RN (1) RN (1 LPN (4) LPN (CNA (7) CNA (6) RN (0) 4) LPN (3) 6) CNA (3)					
	Date: 1/8/17 - census						
	RN (1) RN (1) LPN (4) LPN (3 CNA (7) CNA (6	B) LPN (2)					
	Date:1/9/17 - census	97					
	RN (0) RN (1) LPN (4) LPN (3) CNA (9) CNA (10) training						
	Date: 1/10/17 - censu	us 98					
	RN (0) RN (1) LPN (4) LPN (4 CNA (10) CNA (10) LPN (3)					
	Date: 1/11/17 - censu	ıs 99					
	RN (1) RN (.5 LPN (4) LPN (4 CNA (11) CNA (12	l) LPN (3)					
	Date: 2/6/17 - census	s (not available)					
	RN (1) RN (1 LPN (3) LPN (CNA (10) CNA (3) LPN (2)					
	Date: 2/7/17 census ((not available)					

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

PRINTED: 03/21/2018 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

AND PLAN OF	CORRECTION	IDENTIFICATI	ON NUMBER:	A. BUILDING		COMP	LETED	
								C
		4	95258	B. WING _			02/	23/2017
NAME OF P	ROVIDER OR SUPPLIER				STREE	ET ADDRESS, CITY, STATE, ZIP CODE		
ALITLIMN	CARE OF SUFFOLK				2580 F	PRUDEN BOULEVARD		
AUTUWIN	CARE OF SUFFOLK				SUFF	OLK, VA 23434		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		(X5) COMPLETION DATE
F 353	Continued From page	: 112		F 3	53			
	RN (1) RN (1 LPN (4) LPN (CNA (11) CNA (1	4) LPN (2	2)					
	Date: 2/8/17 census (not available)						
	RN (1) RN (1 LPN (4) LPN (CNA (11) CNA (1	4) LPN (2	2)					
	Date: 2/9/17 census (not available)						
	RN (1) RN (1 LPN (4) LPN (CNA (9) CNA (4) LPN (2	2)					
	Date: 2/10/17 census	102						
	RN (1) RN (1) LPN (4) L CNA (9) C	PN (4)	LPN (2)					
	Date: 2/16/17 census	104						
	LPN (4)	N (1) PN (4) NA (9)	RN (0) LPN (2) CNA (3)					
	Date: 2/17/17 census	105						
	LPN (4)	RN (0) PN (4) NA (11)	RN (0) LPN (2) CNA (3)					

(X2) MULTIPLE CONSTRUCTION

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL ⁻ A. BUILDI		(X3) DATE SURVEY COMPLETED				
			495258	B. WING				23/2017
	NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF SUFFOLK				s 2	STREET ADDRESS, CITY, STATE, ZIP CODE SSUFFOLK, VA 23434	<u> 02//</u>	23/2017
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 353	Continued From page Date 2/18/17 census			F	353			
	LPN (4)	RN (0) LPN (4) NA (10)	RN (0) LPN (2) CNA (2)					
	Date 2/19/17 census	105						
	LPN (4)	RN (1) LPN (4) CNA (8)	RN (0) LPN (2) CNA (3)					
	Date 2/20/17 census	105						
	RN (1) F LPN (4) L CNA (10) C	_PN (4)	RN (0) LPN (2) CNA (3)					
	A Budget analyses probased on a census of Nursing							
	RN .18 = 18.9 hours /8 = 2.36 people I would make this a 3-11 Superior Every day A day shift house supervisor on Sat & Sun, and a 11-7 Supervisor Mon-Friday.							
	LPN .91 = 95.55 hour These are charge/me I would suggest by sh 5-5-2 or 4-5-3 or 5-4-3	ed nurses	staff					
	CNA 2.10 = 220.5 ho I would suggest by sh 12-11-6		9.4 staff					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED			
		495258	B. WING		03	C 2/23/2017	
	ROVIDER OR SUPPLIER CARE OF SUFFOLK			STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434	<u> </u>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 353	or 11-11-7 A Nursing Assistant "Position Summary job position is proviresidents with routin services in accorda assessment and cadirected by your suffunctions, Duties a changes in the reside Supervisor/Charge Report all accidents the shift that they of activities of daily living shaving, dental and dressing/undressing/undressing/assist with lifting, tutransporting resider chairs, bathtubs, whresident with bowel take to bathroom, of commode, etc.) and Report all allegation misappropriation of	a -Job Description Indicated: - The primary purpose of your de each of your assigned he daily nursing care and noce with the resident's re plan, and as may be pervisors. Ind Responsibilities: report all dent's condition to the Nurse Nurse as soon as practical. It is and incidents you observe on cour. Assist residents with ling such as daily hair care, if mouth care, bathing g, and nail care. Inning, moving, positioning and this into and out of beds, heelchairs, lifts, etc. Assist and bladder functions (i.e., ffer bed pan/urinal, portable if provide incontinence care. Its of resident abuse and/or resident property."	F 35	53			
	Description indicate your job position is to the residents, an nursing activities pe assistants. Such su accordance with cu standards, guideling govern our facility, a	Nurse RN/LPN) Job ed: The primary purpose of to provide direct nursing care d to supervise the day-to-day erformed by nursing pervision must be in rrent federal, state, and local es, and regulations that and as may be required by the Services or Nurse supervisor					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		495258	B. WING			C 02/23/2017	
	ROVIDER OR SUPPLIER CARE OF SUFFOLK			STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434	02/23/2017		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 353	to ensure that the his maintained at all As Charge Nurse yeadministrative authoraccountability nece assigned duties. Coreports as necessar informative and desthe care provided to resident's response administer medicating physician. Report a of resident abuse a resident property." On 2/23/17 CNA #2 stated when staffing three (3) and two (2 all of the assigned vertically reposition residents you change and regat the end of the haragain. Your shift by answering call light: An Investigation Residents Indicated: LPN #2 stated than a fall at there was anything resident from falling only four (4) aides." An Investigative regindicated: LPN #1 states and the gain she hadn't been a resident head a fall at the was anything resident from falling only four (4) aides."	ighest degree of quality care times. Ou are delegated the prity, responsibility, and assary for carrying out your emplete accident/incident ry. Chart nurses' notes in an acciptive manner that reflects to the resident, as well as the resident, as well as the rot the care. Prepare and ons as ordered by the red investigate all allegations and/or misappropriation of resident is impossible to do work. We can not change and revery two hours. By the time position each resident you are also resident you are	F 38	53			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495258	B. WING _			C 02/23/2017
	CARE OF SUFFOLK			STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434	'	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 353		n "since there was so much	F 3	53		
F 356	the Administrator, Dir Vice President of Ope Corporate Nurse, when how staff on the 11-7 were tasked out for a CNAs, the DON state assignment of (25) rehave twenty six. The help out." When asked for a census of 105 at the DON, stated each assignment of (35) reinterview the DON was the CNAs expected to stated, "make rounds dry, change residents care, pass water, taken needed." The LPNs were decided. The LPNs were decided as were correctly to the CNAs expected to stated, "make rounds dry, change residents care, pass water, taken needed." The LPNs were decided. The LPNs were decided as were decided. The LPNs were decided as wer	.M. during an interview with rector of Nurses, Regional erations (RVPO) and en asked the question of shift work load assignments a census of 105 for four ed each CNA would have an esidents and one CNA would LPNs would be expected to ed how the work assignment and 3 CNAs be tasked out, in CNA would have an esidents." During this as asked what tasks were or carry out and the DON is, ensure each resident was as as needed and provide perion eresidents to bathroom if were expected to passorders of the day, ensure lab impleted, assist CNAs. Its asked if staff (11-7) shift at being short staffed, and in the provide nursing staff is to provide care and	F 3	56		3/17/17
	CFR(s): 483.35(g)(1)					5/11/11

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495258		B. WING		C 02/23/2017	
	ROVIDER OR SUPPLIER		-	2	TREET ADDRESS, CITY, STATE, ZIP CODE 580 PRUDEN BOULEVARD UFFOLK, VA 23434	, <u> </u>	20,2011
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 356	Continued From page	e 117	F	356			
	the following informat	ts. The facility must post					
	(i) Facility name.(ii) The current date.						
	by the following categ	aff directly responsible for					
	(A) Registered nurses	5.					
	(B) Licensed practical vocational nurses (as	I nurses or licensed defined under State law)					
	(C) Certified nurse aid	des.					
	(iv) Resident census.						
	(2) Posting requireme	ents.					
		ost the nurse staffing data n (g)(1) of this section on a inning of each shift.					
	(ii) Data must be post	red as follows:					
	(A) Clear and readable	le format.					
	(B) In a prominent pla residents and visitors	ace readily accessible to					
	(3) Public access to p	oosted nurse staffing data.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495258	B. WING _		_	02/3	23/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434	,	1 OZIZ	10/2017
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 356	Continued From page 118		F 3	56			
	make nurse staffing d	n oral or written request, lata available to the public ot to exceed the community					
	facility must maintain staffing data for a mir required by State law This REQUIREMENT by: Based on observation facility staff failed to puring the extended of the findings included the pouring the extended of the Nurse Staffing data with the posted daily nurse of the findings included the pouring the extended of the posted daily nurse of the findings included the pouring the extended of the posted data with the posted daily nurse of the posted daily nurse	basis and failed to maintain e staffing data for a ns. : survey the posting of the vas not found. On 2/21/17 at		issue.	are at risk for this designee will fill ou affing and post it at o include: CNAs for each shif	it t	
	the West nursing stat of the Nurse Staffing Administrator shook it don't have it posted." On 2/23/17 at 4:30 pr with the Administrator	nis head and stated, "We m, a meeting was conducted r, the DON, the Regional		3 B The ADON wi sheets for the required 4 A DON or designate the nursing staffing and then randomly 4 B Audit results was meetings. 5. 3/17/17	red 18 months. nee will audit daily to is posted x 60 days x 30 days.	5	
F 490	They indicated that a delegated to post the on a daily basis. The for generating the doc asked if the facility ha Nurse Staffing Inform	ve findings was shared.	F 4	90			3/17/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495258	B. WING		C 02/23/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	02/23/2017
			:	2580 PRUDEN BOULEVARD	
AUTUMN	CARE OF SUFFOLK		;	SUFFOLK, VA 23434	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	5.475
F 490 SS=E	enables it to use its re	n. ninistered in a manner that esources effectively and	F 490		
	efficiently to attain or practicable physical, i well-being of each res This REQUIREMENT by: Based on a complair interviews, the facility resources effectively as well as their education.	maintain the highest mental, and psychosocial sident. is not met as evidenced at investigation, staff staff failed to utilize it and efficiently for personal attion and/ or training.		F-490 1 A On 2/23/17 the Administrator received authority to utiliz Nurse Staffing Agency if needed to provide adequate daily staffing. 1 B The six CNAs cited have obtained the hours needed to meet the hour requirement annually on 2/23/17. 2. All residents are at risk for this	
	effectively and efficient including nurse aides able to maintain their and psychosocial well. The facility staff failed including nurse aides respond to residents'. Two residents (Residwere found with gait to wheelchairs. For residents review of the facility Administrator indicates As the Administrator, administrative authoricaccountability necess	to have sufficient staff to provide care and needs. ent #1 and Resident #3) belts restraining them to dent specific information Tag- 223. 's Job Description for the ed: "Delegation of Authority- you are delegated the ty, responsibility and ary for carrying out your are responsible for carrying		issue. 3 A DON/ADON will create a maschedule for nursing department to facilitate sufficient staffing. 3 B DON will determine number vacant positions and then advertise, recruit, hire for those positions. 3 C DON or designee will review work schedule daily for adequate staffinumbers and will attempt to cover any vacancies (example: call off for sickness with available staff or agency. 3 D DON has designated a on canurse who is to be called if additional staffing is needed. 3 E ADON will audit current CNAs for education hours to ensure that they has the required 12 hours by their annivers date. CNAs identified as needing additional additional staffing and the required 12 hours by their annivers date.	of v ng ss) ill r ve ary

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495258	B. WING			C 2/23/2017	
NAME OF P	ROVIDER OR SUPPLIER	100200		STREET ADDRESS, CITY, STATE, ZIP CO		2/23/2017	
				2580 PRUDEN BOULEVARD			
AUTUMN	CARE OF SUFFOLK			SUFFOLK, VA 23434			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 490	Continued From page	e 120	F 4	90			
	responsible for the or policies established to policies established to Position Qualification Sets- Will need to ha manger facility budge expenses. Understar how to calculate PPE A review of the Direct indicated: "As the Direc	as- Core Competencies/Skill ve knowledge of and ets, including revenue and oding of Hours of Labor and O'S (PER PATIENT DAY)." tor of Nursing (DON) rector of Nursing it your nize, develop and direct the the Nursing Service dance with current federal, ards, guidelines and orn the facility. Outies and Responsibilities- daily calculation of the direct al on duty each shift.		training hours prior to their a be scheduled for appropriat 3 F Each month the A designee will audit training CNAs with approaching and If additional training is requischeduled. 4 A DON or designer nursing staffing to Administrate B QAPI Committee reports from the DON if staff encountered. An action plate developed as needed. 4 C ADON will audit CNA records quarterly to ensure the required 12 hours of ediannually. All audit results will be sharmeeting. 5. 3/17/17	te training. DON or records of niversary date. fred, it will be the will report rator daily. the will receive ffing issues are in will be A training they receive ucation		
	in place. Maintain a master so and enable an accuratimes."	99 N) rse (LPNs) - tance (CNA) 1 11-7					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495258	B. WING			С
NAME OF PI	ROVIDER OR SUPPLIER	495256	B. WING _	STREET ADDRESS, CITY, STATE, ZIP CODE	02/	23/2017
	CARE OF SUFFOLK			2580 PRUDEN BOULEVARD		
AUTOWIN	CARE OF SUFFOLK			SUFFOLK, VA 23434		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTIO X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 490	CNA (7) CNA (6) Date: 1/8/17 - census RN (1) RN (1) LPN (4) LPN (3) CNA (7) CNA (6) Date: 1/9/17 - census RN (0) RN (1) LPN (4) LPN (3) CNA (9) CNA (10) training Date: 1/10/17 - census RN (0) RN (1) LPN (4) LPN (4) CNA (10) CNA (11) Date: 1/11/17 - census RN (1) RN (5) LPN (4) LPN (4) CNA (11) CNA (12) Date: 2/6/17 - census RN (1) RN (1) LPN (3) LPN (4) CNA (10) CNA (6) Date: 2/7/17 census (6)	4) LPN (3) 6) CNA (3) 897 RN (0) LPN (2) CNA (3) 97 RN (0) LPN (2) CNA (5) one staff in 88 98 RN (0) LPN (3) CNA (4) RS 99 PN (0) LPN (3) CNA (5) S (not available) RN (0) S (NA (3) S (not available) RN (0) S (not available) RN (0) S (not available)	F	490		
	RN (1) RN (1) LPN (4) LPN (1)					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SU IDENTIFICATIO		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
					Ī		(0
		49	5258	B. WING _			02/	23/2017
NAME OF P	ROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF SUFFOLK					580 PRUDEN BOULEVARD		
					S	UFFOLK, VA 23434		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICI / MUST BE PRECED .SC IDENTIFYING INI	ED BY FULL	ID PREFII TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 490	Continued From page CNA (11) CNA (1 Date: 2/8/17 census (RN (1) RN (1) LPN (4) LPN (not available) RN (0) 4) CNA (4) RN (0)		F4	490			
	CNA (11) CNA (1) Date: 2/9/17 census (
	RN (1) RN (1 LPN (4) LPN (CNA (9) CNA (4) LPN (2)					
	Date: 2/10/17 census	102						
	RN (1) RN (1 LPN (4) L CNA (9) C	PN (4)	LPN (2) CNA (4)					
	Date: 2/16/17 census	104						
	RN (1) R LPN (4) LF CNA (9) CI		RN (0) LPN (2) CNA (3)					
	Date: 2/17/17 census	105						
	LPN (4) L	RN (0) PN (4) NA (11)	RN (0) LPN (2) CNA (3)					
	Date 2/18/17 census	105						
	LPN (4)	RN (0) PN (4) NA (10)	RN (0) LPN (2) CNA (2)					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495258	B. WING			02/	23/2017
	ROVIDER OR SUPPLIER		•	25	TREET ADDRESS, CITY, STATE, ZIP CODE 580 PRUDEN BOULEVARD UFFOLK, VA 23434		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 490	Continued From page	e 123	F	490			
	LPN (4) L CNA (10) C A Budget analyses pr based on a census of Nursing RN .18 = 18.9 hours / I would make this a 3	RN (1) RN (0) LPN (4) LPN (2) CNA (8) CNA (3) 105 RN (0) RN (0) LPN (4) LPN (2) CNA (11) CNA (3) resented by the Administrator f 105 indicated: "Hands on /8 = 2.36 people -11 Superior Every day pervisor on Sat & Sun, and a -Friday. rs /8 = 11.94 staff red nurses hift urs /7.5 = 29.4 staff					
	A Nursing Assistant "Position Summary - '	Job Description Indicated: The primary purpose of your e each of your assigned					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		DNSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495258	B. WING			l	23/2017
	ROVIDER OR SUPPLIER			2580	EET ADDRESS, CITY, STATE, ZIP CODE PRUDEN BOULEVARD FOLK, VA 23434	1 021	23/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 490	services in accordance assessment and care directed by your super functions, Duties and changes in the resided Supervisor/Charge N Report all accidents at the shift that they occactivities of daily livin shaving, dental and redressing/undressing, Assist with lifting, turn transporting residents chairs, bathtubs, whe resident with bowel at take to bathroom, officommode, etc.) and present all allegations misappropriation of red. A Nursing (Charge N Description indicated your job position is to to the residents, and nursing activities perferon assistants. Such super accordance with curn standards, guidelines govern our facility, and Director of nursing Services.	de daily nursing care and ce with the resident's a plan, and as may be ervisors. de Responsibilities: report all ent's condition to the Nurse curse as soon as practical. and incidents you observe on eur. Assist residents with grace such as daily hair care, nouth care, bathing and nail care. Ining, moving, positioning and is into and out of beds, selchairs, lifts, etc. Assist and bladder functions (i.e. er bed pan/urinal, portable provide incontinence care, of resident abuse and/or esident property." The primary purpose of provide direct nursing care to supervise the day-to-day formed by nursing ervision must be in ent federal, state, and local and as may be required by the ervices or Nurse supervisor hest degree of quality care	F	190			
	As Charge Nurse you administrative author	ı are delegated the ity, responsibility, and					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		495258	B. WING _			C 02/23/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434	DE	02/20/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIA	
F 490	assigned duties. Com reports as necessary informative and describe care provided to the care provided to the care provided to the care provided to the resident's response the administer medication physician. Report and of resident abuse and resident property." On 2/23/17 CNA #2 with stated when staffing the three (3) and two (2) all of the assigned work reposition residents everyou change and reposition residents. An Investigation Reprindicated: LPN #2 states "Yes, I helped the nurresident had a fall at there was anything wresident from falling, only four (4) aides." An Investigative repoindicated: LPN #1 states "LPN #2 put the gait is she hadn't been a nudidn't think anything a him from falling again paperwork with a fall. On 2/23/17 at 3:20 P	cary for carrying out your applete accident/incident. Chart nurses' notes in an ariptive manner that reflects the resident, as well as the control the care. Prepare and as as ordered by the dinvestigate all allegations dor misappropriation of the 11-7 shift is down to aides it is impossible to doork. We can not change and every two hours. By the time sition each resident you are and have to start all over his time is over. We are also that during the investigation, are locate a gait belt after the Reflect American Manner of the stated that there was art dated February 10, 2017 atted during the investigation, and that since are as long as LPN #2 she about it. She wanted to keep a since there was so much	F	490		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495258	B. WING			C / 23/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434	1 02	720/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 490	and Corporate Nurse of how staff on the 12 assignments were ta for four CNAs, the Do would have have an and one CNA would would be expected to the work assignment CNAs be tasked out, would have an assign During this interview task were the CNAs DON stated, "make r was dry, change resi peri care, past water, if needed." The LPNs medications, review work orders were con The Administrator was had complained abour replied, "Yes". When asked for a Standinistrator and the "Staffing Policy". The facility staff failed effectively and efficied including nurse aides able maintain their hipsychosocial well -be	lent of Operations (RVPO) e, when asked the question 1-7 shift work loads sked out for a census of 105 ON stated, "each CNA assignment of (25) residents have twenty six. The LPNs of help out." When asked how for a census of 105 and 3 the DON, stated each CNA nment of (35) residents the DON was asked what expected to carry out? The rounds, ensure each resident dents as needed and provide take residents to bathroom swere expected to pass orders of the day, ensure lab mpleted, assist CNAs. as asked if staff (11-7) shift at being short staffed, and he affing Policy, the the RVPO stated there was no d to administer its resources ently to provide nursing staff to to ensure residents were tighest physical, mental and being.	F 4			
	COMPLY WITH FED LAWS/PROF STD CFR(s): 483.70(b)(c)	ERAL/STATE/LOCAL	F 4	92		3/17/17

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED
		495258	B. WING _		02/23/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434	1 02/20/2011
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE COMPLETION
F 492	Laws and Profession The facility must op compliance with all local laws, regulation accepted profession that apply to profess such a facility. (c) Relationship to Compliance in the applicable proving regulations, including pertaining to nondiscrimination on CFR part 84); nonding (45 CFR part 9); basis of race, color, disability (45 CFR profession of the subjects of research and abuse (42 CFR individually identifiant CFR parts 160 and provisions may resund provisions may resund provisions may resund the subjects of research and abuse (42 CFR individually identifiant CFR parts 160 and provisions may resund pro	a Federal, State, and Local nal Standards. erate and provide services in applicable Federal, State, and ns, and codes, and with hal standards and principles sionals providing services in Other HHS Regulations. itance with the regulations set facilities are obliged to meet sions of other HHS go but not limited to those crimination on the basis of hal origin (45 CFR part 80); in the basis of disability (45 secrimination on the basis of 1); nondiscrimination on the national origin, sex, age, or art 92); protection of human in (45 CFR part 46); and fraud part 455) and protection of ble health information (45 164). Violations of such other alt in a finding of in this paragraph. IT is not met as evidenced wint investigation, and staff try staff failed to comply with Local laws for reporting abuse ers.	F 4	F-492 1 A FRI was submitte DOH/OLC and all other required a regarding res. # 1 & 3. 1 B 100% of all current employ were in-serviced regarding the revalue Prevention and Mandated Reporter. 2. All residents are at risk for this	agencies /ees vised

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION		E SURVEY MPLETED
		495258	B. WING			C 2/23/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434		2/23/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 492	an incident of abuse in Mandated Reporters. Two residents (Resid were found with gait is wheelchairs. For residences reference to Fare A review of the facility Administrator indicate As the Administrator, administrative authorical accountability necess assigned duties. You out the operational consistence of the own policies established by the consequence of the	ent #1 and Resident #3) Delts restraining them to dent specific information Tag- 223. It's Job Description for the ed: "Delegation of Authority-you are delegated the ty, responsibility and ary for carrying out your are responsible for carrying ore responsibilities mpany and facility. You are resight of the resident care by the facility. al Function, Duties, and deministrator is responsible epartment's activities, and deministrator is responsible epartment attains and a with State and federal ibilities- Maintain a ritten material, laws, etc. ing with current standards that will provide assistance of the erate. Must have ules and regulations for the erate. Must have knowledge ts for Long Term Care e Safety Code.	F 49	3 A All new hires will be educated Abuse Prevention and Reporting and Procedure. Current employe be in-serviced annually. 3 B Administrator or DON will in FRI process and investigation for allegations of abuse. Abuse Prevand Reporting Policy & Procedur followed. 4 A All incidents of alleged abuaudited by the Administrator and assure they were reported to the DOH/OLC and other agencies. 4 B Audit results will be shared meetings. 5. 3/17/17	Policy ees will mplement fall vention e will be use will be DON to	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		495258	B. WING _			C 02/23/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434	ZIP CODE	32/20/20 11
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTIVE CROSS-REFERENCEE	N OF CORRECTION E ACTION SHOULD B D TO THE APPROPRIA CIENCY)	DATE
F 492	overall operations of Department in according state and local stand regulations that gove In the area of Essent Responsibilities the I reporting of any know of abuse and/or misa property in accordant A Review of the Virgi Services Mandated in the Administrator and until February 22, 20. The State Code for in Code 63.2-1603 through the employees have mandated report state report or cause a report or cause a report or cause a report ective Services ((1-800) Hot Line or an of social services who cause to suspect that an incapacitated adding known to me in my capacity may be abused to suspect that an incapacitated adding the survey the several times what go operation Manual-Since Administrator/Dowere not aware that symptoms and without assessment was considered.	nize, develop and direct the the Nursing Service dance with current federal, ards, guidelines and ern the facility. tial function, duties, DON is responsible for the wn or suspected allegations appropriation of resident ce to the state guidelines. Inia Department Social reporter notification form for d the DON was not signed 17. Inandated reporting include: sugh 1610. This means that been notified of their tus. They are required to roor to be made to state Adult APS) either by calling the appropriate local department enever they have reasonable to an adult age 60 or over or all taged 18 and over and who are professional or official sed, neglected, or exploited." Administrator was asked uidelines (Standards of a CoM) they were operating. ON repeatedly stated they a restraint without medical ut a a physicians order and	F	192		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	` ′сомі	E SURVEY PLETED
		495258	B. WING _			C / 23/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434	1 02	720/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 492	of regulations were ther self operating ungot a down load of re 2017." She informed load were correction: When asked to see the Administrator was oppresented. A revised Policy date Indicated: "Policy: It investigate all allegatincidents of abuse, nexploitation of resideresident property and Definitions: Abuse-in willful infliction of injuconfinement, intimidate resulting physical harincludes verbal abuse or enabled through the misappropriation of rexploitation, involunt unknown source, phyrestraints. Restraints-(physical used per MD order aregulations and guid Management P & P of The facility staff faile	ons she was asked which set the Administrator as well as der and she stated, "I just egulations on February 9, the surveyor that the down is which she was aware of. The (SOM) in-which the perating, no copy was add; February 21, 2017 as the facility's policy to the dions, suspicions and eglect, involuntary seclusion, ints. misappropriation of dinjuries of unknown source. The cludes actions such as the arry, unreasonable ation, or punishment with rim, pain or mental anguish. It is including abuse facilitated the use of technology, esident property, arry seclusion and injuries of visical and chemical The compliance with the lines of Fall prevention and incompliance with gelines of Fall prevention and incompliance with the lines of Fall prevention and t	F4	92		
F 497	Abuse for two reside NURSE AIDE PERF	nts. ORM REVIEW-12 HR/YR	F 4	97		3/17/17

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3)	(X3) DATE SURVEY COMPLETED	
		495258	B. WING			C 02/23/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434	· '	02/20/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 497 SS=E	of every nurse aide a months, and must producation based on treviews. In-service to requirements of §483 This REQUIREMENT by: Based on staff interview the facility stanurse aide received rin-service education. The findings included During the abbreviate practices were identification Policies and Procedu Neglect and Exploitations was called on 2/21/1 survey included the reducation of nurse aid. The ADON (Assistant (Staff Development Coprovide a list of all en 12 hours of in-service by employment date.	plete a performance review t least once every 12 ovide regular in-service he outcome of these raining must comply with the 3.95(g). To is not met as evidenced riew and facility document ff failed to ensure each no less than twelve hours of per year. It: The description of the service decoration of the service description of the service description of the service decoration decoration of the service decoration of the service decoration of the service decoration decoration of the service decoration d	F 49	F-497 1. The six CNAs cited obtained the hours needed to rhour requirement annually on 2. All residents are at risk issue. 3 A ADON will audit curr for education hours to ensure thave the required 12 hours by anniversary date. 3 B CNAs identified as neadditional training hours prior to anniversary will be scheduled fappropriate training. 3 C Each month the ADO designee will audit training reconstruction of the control o	meet the 12 2/23/17. for this rent CNAs that they their eeding o their for ON or ords of ersary date. I, it will be aining ey receive ation		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495258	B. WING			C	
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF SUFFOLK				STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETIC DATE		
F 497	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F 4	97	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		